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INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7101 Date of this Memo 03/30/2010 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

QUESTION: Are poststabilization care services included in the definition and coverage requirements of emergency services?

ANSWER: Yes. Beneficiaries have access to poststabilization care services 24 hours a day, seven days a week, both inpatient and outpatient, related to an emergency medical condition, while the beneficiary is within the United States at the time such services are needed, that are provided after a beneficiary is stabilized in order to maintain the stabilized condition, or, pursuant to 42 CFR §438.114(e), to improve or resolve the beneficiary's condition.

Poststablization care services means covered services, related to an emergency medical condition that are provided after a beneficiary is stabilized in order to maintain the stabilized condition.

The OVHA shall cover poststabilization care services necessary to stabilize a beneficiary and does not require prior authorization of such services.

Payment for such services will be made by enrolling the provider, if otherwise eligible, in the Vermont Medicaid program.

Medicaid Benefit Delivery

7101 Medicaid Benefit Delivery (07/26/2012, 12-01)

Eligible beneficiaries receive covered services through either the fee-for-service or a managed health care delivery system. Most beneficiaries are required to receive covered services through a managed health care delivery system. The following beneficiaries are exempt from managed health care enrollment and will receive covered services through the fee-for-service delivery system:

A. home and community-based waiver beneficiaries;

B. beneficiaries living in long-term care facilities, including ICF/MRs;

C. beneficiaries who are receiving hospice care when they are found eligible for Medicaid;

D. children under age 21 enrolled in the high-tech home care program;

E. beneficiaries who have private health insurance that includes both hospital and physician services or beneficiaries who have Medicare (Parts A and/or B);

F. beneficiaries who meet a spend-down who are not enrolled in a VHAP managed health care plan; and

G. beneficiaries whose requirement to enroll in a managed health care delivery system is anticipated to last for three or fewer months based on known changes, such as imminent Medicare eligibility.

If the beneficiary is not exempt under subsections A-G above, he or she will be required to receive covered services through a managed health care delivery system.

Choice Options for Beneficiaries Subject to the Managed Health Care Delivery System Requirement

Options 1 through 4 below apply to beneficiaries who belong to a category of beneficiaries to whom one or more commercial managed care plans have a contractual obligation to offer plan enrollment.

Option 1 – When the beneficiary belongs to a category of beneficiaries for whom two or more commercial managed care plans have a contractual obligation to offer plan enrollment and the beneficiary resides in a geographic area in which two or more commercial managed care plans have the capacity to accept new plan enrollees, the beneficiary's choice is enrollment in one of the two or more commercial managed care plans available.

NOTE

The standards the department uses to determine the geographic area that a managed health care plan serves are defined in the Medicaid Procedures Manual at P-2443; these standards are in accordance with federal standards for access to care and the Department of Banking, Insurance, Securities and Health Care Administrations Rule 10.

Option 2 – When the beneficiary belongs to a category of beneficiaries for whom one or more commercial managed care plans have a contractual obligation to offer plan enrollment, the beneficiary resides in a geographic area in which only one commercial managed care plan has the capacity to accept new plan enrollees, and the beneficiary's city or town of residence is served by two or more PCCM providers who are available, accessible, and appropriate, the beneficiary's choice is between enrollment in the one commercial managed care plan available or enrollment in the PCCM program. This option is subject to approval by the Centers for Medicare and Medicaid Services.

Option 3 – When the beneficiary belongs to a category of beneficiaries for whom one or more commercial managed care plans have a contractual obligation to offer plan enrollment and all commercial managed care plans lack the capacity to accept new plan enrollees, and the beneficiary's city or town of residence is served by two or more PCCM providers who are available, accessible, and appropriate, the beneficiary's choice is to enroll in the PCCM program. This option is subject to approval by the Centers for Medicare and Medicaid Services.

Option 4 – When the beneficiary belongs to a category of beneficiaries for whom one or more commercial managed care plans have a contractual obligation to offer plan enrollment and all commercial managed care plans lack the capacity to accept new plan enrollees, and the beneficiary's city or town of residence is served by only one PCCM provider who is available, accessible, and appropriate, the beneficiary's choice is to select the PCCM program or choose to receive services through the fee-for-service system. This option is subject to approval by the Centers for Medicare and Medicaid Services.

Options 5 and 6 below apply to beneficiaries who belong to a category of beneficiaries for whom enrollment in a commercial managed care plan is not available due to absence of a plan that has a contractual obligation to offer plan enrollment to this category of beneficiaries.

Option 5 – When the beneficiary's city or town of residence is served by two or more PCCM providers who are available, accessible, and appropriate, the beneficiary's choice is to enroll in the PCCM program. This option is subject to approval by the Centers for Medicare and Medicaid Services.

Option 6 – When the beneficiary's city or town of residence is served by only one PCCM provider who is available, accessible, and appropriate, the beneficiary's choice is to enroll in the PCCM program or choose to receive services through the fee-for-service system. This option is subject to approval by the Centers for Medicare and Medicaid Services.

When none of the above options applies, the beneficiary receives Medicaid-covered services through the fee for service system.

A benefit counselor will assist beneficiaries in making an informed choice among available managed health care delivery system options. When enrollment in a managed care delivery system is not mandatory, a benefits counselor will assist beneficiaries in making an informed choice between enrolling in a managed health care delivery system or remaining in the fee-for-service system.

7101.1 Fee-For-Service (07/26/2012, 12-01)

Payment is made using a fee-for-service reimbursement system for:

- services furnished to beneficiaries not required to enroll in managed health care plans who are ineligible for voluntary enrollment,
- services furnished to beneficiaries who are eligible for voluntary enrollment and have chosen not to enroll,
- certain wrap-around and other services not included in the contracts with managed health care plans, and
- services furnished to beneficiaries during retroactive periods of eligibility or prior to enrollment in managed health care plans.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

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Reference 7101.2 Date of this Memo 07/01/2013 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

QUESTION: Have there been any changes to co-payment requirements?

ANSWER: Yes. Act 50 of the 2013–2014 Vermont Legislative Session removed co-payments requirements for Durable Medical Equipment (DME) and Supplies.

This process includes the following steps the department, the eligible Medicaid beneficiary and the medical care provider must take for the provider to receive payment for services given to the beneficiary.

The department must:

- give each Medicaid eligible person an identification document showing that the person has been found eligible for Medicaid,
- accept and process all provider claims itself or through its administrative agent, and
- notify providers of decisions on claims and pay approved claims.

The beneficiary must:

- tell the provider he or she wants the provider's services charged to Medicaid,
- advise the provider if he or she has private health insurance coverage in addition to Medicaid,
- accept liability for any applicable co-payment (see Obligation of Receipts), and
- show the provider his or her identification document if it has been issued.

The provider must:

- verify that the beneficiary is still eligible for Medicaid on the date the service is provided,
- bill any other liable third parties prior to billing Medicaid,
- accept the Medicaid payment rate as payment in full and bill the beneficiary only for any applicable co-payments once Medicaid has been accepted as a source of payment,
- give a Medicaid covered service (see rules 7200 - 7600), and
- file a claim with the department or its agent, including all necessary information about the service and the identifying information from the beneficiary's identification document.

Rules and time limits for these steps are given in rules 4160-4164, 7105–7108, and 7201-7203.

7101.2 Managed Health Care Plan (08/01/2012, 12-05)

Under a managed health care plan, a per-person payment for a defined array of services is made to the plan each month for each enrolled member.

Upon enrollment, managed health care plans shall provide their members with handbooks that include information such as the following:

- what services are covered and how to access those services;
- the procedures for changing primary care providers;
- the procedures for obtaining specialty referrals;
- services that do not require a primary care provider referral;
- services that are covered as wrap-around benefits;
- appointment procedures and information on what to do in a medical emergency;
- information about member rights and responsibilities;

- information on how to register a complaint or file a formal grievance with the plan.

A. Managed Health Care Plan Services

Medicaid beneficiaries enrolled in managed health care plans are eligible for the same range of medically necessary services as those beneficiaries in the fee-for-service system.

1. Services Requiring Plan Referral

The following services as defined in the State Plan and by regulation are included in the monthly payments made to the managed health care plans subject to negotiated contract provisions and must be accessed through the beneficiary's primary care provider (Medicaid regulatory citations are indicated where applicable):

- inpatient services (rule 7201);
- outpatient services in a general hospital or ambulatory surgical center (rule 7203);
- physician services (rules 7301–7310);
- medical and surgical services of a dentist (rule 7311);
- covered organ and tissue transplants, including expenses related to providing the organ or doing a donor search (rule 7305);
- home health care (rule 7401);
- hospice services by a Medicare-certified hospice provider (rule 7402);
- outpatient therapy services (home infusion therapies and occupational, physical, speech and nutrition therapy) (rules 7203, 7401);
- prenatal and maternity care (rules 7201, 7301);
- medical equipment and supplies (rules 7504, 7505);
- skilled nursing facility services for up to 30 days length of stay per episode (rule 7601);
- mental health and chemical dependency services (rule 7403.1);

  NOTE: If a participating managed health care plan has a contract with an institution for mental diseases, services are limited to 30 days per episode and 60 days per calendar year.

- podiatry services (rule 7308);

2. Self-Referral Services

The following services are also included in the monthly payments made to the health plans, but may be accessed by health plan enrollees from the plan's network providers without a referral from their primary care provider:

- unlimited visits per calendar year to a network gynecological health care provider for reproductive or gynecological care, as well as visits related to follow-up care for problems identified during such visits;
- one mental health and chemical dependency visit (plans may determine the number of visits beyond the initial visit that can be provided before authorization is required

from the plan's mental health and substance abuse intake coordinator, or primary care physician); and

- one routine eye examination every 24 months (rule 7316).

B. Wrap-Around Benefits

Medicaid beneficiaries enrolled in managed health care plans are eligible to receive additional services as defined in the State Plan and by regulation that are not included in the managed health care plan package. Some of these services do not require a referral from the beneficiary's primary care provider and are reimbursed on a fee-for-service basis. Examples of these services are:

- transportation services (rule 7408);
- dental care for children under age 21 (rule 7312) and limited dental services for adults up to the annual benefit maximum (rule 7313);
- eyeglasses for children under age 21 furnished through the department's sole source contractor (rule 7316);
- chiropractic services (rule 7304);
- family planning services (defined as those services that either prevent or delay pregnancy);
- personal care services (rule 7406); and
- prescription drugs and over-the-counter drugs prescribed by a physician for a specific disease or medical condition (rules 7502-7502.6).

C. Cost Sharing

Medicaid beneficiaries age 21 and older are subject to the following copayment requirements, unless exempt under rule 4161 (B):

- $3.00 per day per hospital for hospital outpatient services unless the beneficiary is also covered by Medicare. A beneficiary covered by Medicare has no co-payment requirement for outpatient services.
- $3.00 for each dental visit.
- Prescriptions and durable medical equipment/supplies:
  - $1.00 for each prescription (original or refill) or durable medical equipment/supplies having a usual and customary charge of less than $30.00;
  - $2.00 for each prescription (original or refill) or durable medical equipment/supplies having a usual and customary charge of $30.00 or more but less than $50.00;
  - $3.00 for each prescription (original or refill) or durable medical equipment/supplies having a usual and customary charge of $50.00 or more.

D. Enrollment

1. Choice of Managed Health Care Delivery System

   a. When beneficiaries are required to enroll in a managed health care plan (rule 7101 Option 1), a benefit counselor will assist beneficiaries in making an informed choice among available managed health care plan options. The benefits counselor will

initiate a follow-up contact with a beneficiary who has failed to notify the benefits counselor of his or her decision of a plan and will provide additional information if requested to do so. If no choice has been made within 30 days of being contacted, the benefits counselor will assign the beneficiary to a managed care plan using a state-approved algorithm.

i. All eligible members of a Medicaid group are expected to select the same managed health care plan, except when it creates a hardship or a different plan is indicated for medical reasons. The department reserves the right to determine, in these specific cases, when enrollment in a different managed health care plan is indicated.

ii. Beneficiaries enrolled in managed health care plans will be required to select a primary care provider (PCP) from among the plan's network of providers. The benefits counselor will provide beneficiaries with information about each plan's provider network so that they may select a PCP at the time of enrollment or when contacted by the plan. A beneficiary who fails to select a PCP will have one assigned by the plan. Once assigned, beneficiaries may make subsequent changes in their PCP every 30 days with fifteen days notice to the managed health care plan. A beneficiary's stated preference is contingent upon the availability of the chosen PCP.

b. When beneficiaries are required to enroll in a managed health care plan or the PCCM program (rule 7101 Options 2 and 3), a benefit counselor will assist beneficiaries in making an informed choice among available managed health care plans and the PCCM program. The benefits counselor will initiate a follow-up contact with a beneficiary who has failed to notify the benefits counselor of his or her decision to enroll in a plan or the PCCM program and will provide additional information if requested to do so. If no choice has been made within 30 days of being contacted, the benefits counselor will assign the beneficiary to a managed care plan or the PCCM program and a PCCM provider using a state-approved algorithm.

2. Change of Managed Health Care Plan

Enrollees may change their choice of managed health care plan for any reason within 30 days of the effective date of coverage under a plan. Members may change plans once per year thereafter, and at other times for good cause. Good cause is limited to the following circumstances:

- The beneficiary notifies the department of a change in his or her place of residence and, as a result, is outside the service area of the plan.
- The department has found that there is a rational and justifiable reason for determining that good cause exists, or, upon appeal, the Human Services Board finds good cause exists.

Managed health care plan changes will become effective on the first day of the following month, if all required actions have been completed on or before the 15th day of the prior month. Otherwise, the change shall become effective the first of the second month after all required actions are completed.

At least 30 days prior to the anniversary date, enrollees will receive a notice of their opportunity to renew their enrollment with their current managed health care plan or to choose another plan. Information about the plan options and assistance available in making a selection will be included in the notice.

3. Disenrollment

In rare instances it may become necessary to pursue disenrollment of beneficiaries who are intentionally unresponsive to basic managed care expectations. The following may be disenrolled:

- Beneficiaries who pose a threat to plan employees or other members.
- Beneficiaries who regularly fail to arrive for scheduled appointments without canceling, despite documented aggressive outreach efforts by the managed health care plan.
- Beneficiaries who do not cooperate with treatment and have not made an affirmative decision to refuse treatment, despite documented aggressive outreach efforts by the plan.

Grounds for disenrollment does not include beneficiaries who have cooperated with the plan in its effort to inform them fully of the treatment options and the consequences of their decisions regarding treatment and who have subsequently made an informed decision to refuse treatment.

Plan disenrollment requests must conform to criteria for disenrollment established by the department. Managed health care plans must notify the affected member, or his or her designated representative, in writing, of a plan-initiated request for disenrollment. Only the department may disenroll a member from a managed health care plan.

Beneficiaries remain in the managed health care plan until the department decides to disenroll the beneficiary. Beneficiaries are notified of this decision in writing and of their right to request a fair hearing before the Human Services Board. Medicaid beneficiaries who are disenrolled, unless enrolled in another managed health care plan or the PCCM program immediately thereafter, will receive services through the traditional fee-for-service system.

4. New Enrollees

An individual not enrolled in a Medicaid managed health care plan who joins a Medicaid group will be enrolled in the head of household's managed health care plan. An individual already enrolled in a managed health care plan who joins another Medicaid group will remain in his or her current health plan until the next review. Subsequent changes in managed health care plan enrollment may be made in accordance with provisions under Change of Managed Health Care Plan.

E. Appeals of Managed Health Care Plan Decisions

Beneficiaries enrolled in managed health care plans have the right to appeal medical care decisions made by the managed health care plans based on medical/clinical necessity determinations. Although the Medical Director of the managed health care plan will make medical/clinical determinations, the department retains the authority to review and affirm or deny such determinations made by the managed care plans.

Beneficiaries first must seek remedy of a medical care decision through the managed health care plan's formal grievance process. The managed health care plan may take up to 15 days to seek resolution of a complaint related to medical care and must address issues in fewer than 15 days if warranted by the patient's condition. Plans may take up to 30 days to seek resolution of a complaint not related to medical care. The decision of the managed health care plan shall be in writing and shall be sent to the beneficiary and to the department.

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Reference 7101.3 Date of this Memo 07/01/2013 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

QUESTION: Have there been any changes to co-payment requirements?

ANSWER: Yes. Act 50 of the 2013–2014 Vermont Legislative Session removed co-payments requirements for Durable Medical Equipment (DME) and Supplies.

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Reference 7101.3 **Date of this Memo** 01/06/2012 **Page** 1 of 1
This Memo: [ ] is New [X] Replaces one dated 05/01/2008

QUESTION: Has there been a change in what practitioners may be considered primary care providers (PCP)?

ANSWER: Yes. Act 88 of the Vermont Legislature authorized the OVHA to provide coverage for medically necessary health care services within the Medicaid benefit package provided by a Naturopathic Physician (N.D.). N.D.s must be licensed in Vermont and provide treatment within the scope of their practice as described in chapter 81 of Title 26 of the Vermont Statutes Annotated. N.D.s having either local admitting hospital privileges or a formal arrangement with a physician who have local hospital admitting privileges and arrange 24 hour-a-day / seven days-a-week coverage for their patients may enroll as PCP's with Vermont Medicaid. N.D.s looking to enroll as PCPs should contact EDS and review the Vermont Medicaid Provider Manual for more information.

N.D.s who do not meet the above conditions to become a PCP for Vermont Medicaid are considered specialists.

If a beneficiary disagrees with the decision resulting from the managed health care plan's grievance process, he or she may request a fair hearing.

A managed health care plan must provide a service if it is determined medically/clinically necessary by the department.

7101.3 Primary Care Case Management (PCCM) (08/01/2012, 12-05)

The primary care case management (PCCM) program is a managed health care service delivery system that requires a beneficiary to choose a primary care provider (PCP) and to access specified medical care through this provider. The primary care provider (PCP) will provide and coordinate medical care for the beneficiary through direct service delivery or by making appropriate referrals to other providers for necessary services.

Payments are made to providers using the fee-for-service reimbursement method.

For beneficiaries enrolled in the PCCM program specialty services require referral, unless the service is designated as a self-referral service. See rule 7101.3(D).

A. Definitions

1. “Adverse determination” means a determination by the DVHA that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the DVHA's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced or terminated.

2. “Ambulatory review” means utilization review of health care services performed or provided in an outpatient setting.

3. “Case management” means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

4. “Certification” means a determination by the DVHA or its designated utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the DVHA's requirements for medical necessity, appropriateness, health care setting, level and intensity of care and effectiveness.

5. “Clinical peer” means a health care provider who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically provides or manages the medical condition, procedure or treatment under review.

6. “Clinical review criteria” means the written screening procedures, decision abstracts, clinical protocols, practice guidelines and utilization management and review guidelines used by the DVHA to determine the necessity and appropriateness of health care services.

7. “Commissioner” means the Commissioner of the Department of Vermont Health Access.

8. “Concurrent review” means utilization review conducted during a beneficiary's hospital stay or course of treatment.

9. “Confidentiality code” means the confidentiality requirements applicable to the DVHA under state and federal law.

10. "Credentialing verification" means the process of obtaining and verifying information about a health care provider sufficient to determine if the provider can be enrolled as a participating provider in the Medicaid program.

11. "DVHA" means the Department of Vermont Health Access.

12. "Discharge planning" means the formal process for determining, before discharge from a health care facility, the coordination and management of the care that a beneficiary will receive following the discharge.

13. "Emergency medical condition" means the sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possess an average knowledge of health and medicine, to result in:

    a. placing the member's physical or mental health in serious jeopardy; or

    b. serious impairment to bodily functions; or

    c. serious dysfunction of any bodily organ or part.

14. "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

15. "Grievance" means a written or oral complaint submitted by or on behalf of a beneficiary regarding the:

    a. availability, delivery or quality of health care services; or

    b. claims payment, handling or reimbursement for health care services.

16. "Gynecological health care services" means preventive and routine reproductive health and gynecological care, including annual screening, counseling, and treatment of gynecological disorders and diseases in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists.

17. "Gynecological health care provider" means a health care provider or health care facility that is primarily engaged in providing gynecological health care services.

18. "Health care provider" or "provider" means a person, partnership or corporation, other than a facility or institution, licensed or certified or authorized by law to provide professional health care service to an individual during that individual's medical care treatment or confinement.

19. "Health care facility" means all facilities and institutions, whether public or private, proprietary or nonprofit, that offer diagnosis, treatment, inpatient or ambulatory care to two or more unrelated persons. The term shall not apply to any facility operated by religious groups relying solely on spiritual means through prayer or healing, but includes all facilities and institutions included in 18 V. S. A. §9432(10).

20. "Health care services" or "services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

21. "Medical Director" means a health care provider who is board-certified or board-eligible in his or her field of specialty and who is charged by the DVHA with responsibility for overseeing all clinical activities of the PCCM program, or his or her designee.

22. "Medically-necessary care" is defined at rule 7103.

23. "Green Mountain Care Network" or "Network" means a collective of enrolled providers comprised of Vermont and select out-of-state hospitals and their affiliated providers due to their close proximity to Vermont and that it is the general practice of residents of Vermont to secure care and services in that locality.

24. "Peer review committee" means a committee as defined in 26 V. S. A. §1441, and for purposes of this rule includes any committee established by the DVHA pursuant to 18 V. S. A. §9414(c)(1) and 10.202(G)(1) of this rule.

25. "Person" means a natural person, partnership, unincorporated association, corporation, limited liability company, municipality, the state of Vermont or a department, agency or subdivision of the state, or other legal entity.

26. "Primary care provider" is defined at rule 7101.3(B).

27. "Primary care services" include services provided by providers specifically trained for and skilled in first-contact and continuing care for persons with undiagnosed signs, symptoms or health concerns, not limited by problem origin (biological, behavioral or social), organ system or diagnosis. Primary care services include health promotion, disease prevention, health maintenance, counseling, patient education, case management, and the diagnosis and treatment of acute and chronic illnesses in a variety of health care settings.

28. "Prospective review" or "prior authorization" means utilization review conducted before an admission or a course of treatment. (See also rule 7102.)

29. "Quality assurance program" means a set of procedures and activities designed to safeguard or improve the quality of medical care by assessing the quality of care or service, usually against a set of established standards, and taking action to improve it.

30. "Quality improvement" means the effort to improve the level of performance of and outcomes of treatment delivered to beneficiaries. Opportunities to improve care and service are found primarily by continual examination of, and continual feedback and education about how services are provided.

31. "Quality of care" means the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes, decrease the probability of undesired health outcomes, and are consistent with current professional knowledge.

32. "Referral" means that a PCP has authorized that a beneficiary should have one or more appointments with a health care provider for consultation, diagnosis, or treatment of a medical condition, to be covered as a benefit.

33. "Retrospective review" means utilization review of medical necessity that is conducted after services have been provided to a beneficiary, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

34. "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the proposed service.

35. "Secondary verification" means verification of a health professionals credentials based on evidence obtained by means other than direct contact with the issuing source of the credential (*e.g.*, copies of certificates provided by the applying health professional).

36. "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result or occur before a beneficiary can be transferred.

37. "Urgently-needed care" or "urgent care" means those health care services that are necessary to treat a condition or illness of an individual that if not treated within twenty-four (24) hours presents a serious risk of harm.

38. "Utilization management" means the set of organizational functions and related policies, procedures, criteria, standards, protocols and measures used by the department to ensure that it is appropriately managing access to and the quality and cost of health care services provided to its beneficiaries.

39. "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prior authorization, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

40. "Utilization review guidelines" mean the normative standards for resource utilization for various clinical conditions and medical services that are used by the DVHA in deciding whether to approve or deny health care services.

41. "Utilization review organization" means an entity that conducts utilization review, other than the DVHA performing a review for its own beneficiaries.

B. Primary Care Provider (PCP)

Under this system a payment is made to the primary care provider (PCP) each month for case management services provided to each beneficiary enrolled with the PCP. Family practitioners, general internists, pediatricians, or doctors of general medicine, that are enrolled with Vermont Medicaid may become a PCP in the PCCM program. Specialists may become a PCP only under the conditions described below. The PCP selected by a beneficiary shall coordinate needed medical services. PCPs will be responsible for providing beneficiaries with referrals to specialists when in their judgement it is considered medically necessary; for coordinating all ancillary, outpatient and inpatient services; and for preventing the duplication of services.

If a beneficiary has either a life-threatening condition or disease, or a degenerative or disabling condition or disease, that requires specialized medical care over a prolonged period of time, a specialist with expertise in treating the condition or disease may act as the beneficiary's PCP. If a specialist agrees to act as the PCP, the specialist shall provide and coordinate medical care for the beneficiary through direct service delivery or by making appropriate referrals to other providers for necessary services. The DVHA Medical Director must review and approve of such arrangements before a specialist may become the PCP. If the request is denied by DVHA, the beneficiary has the right to appeal DVHA's decision and to request a fair hearing.

C. Services Requiring a PCP's Referral

The following services must be accessed through the beneficiary's PCP and are subject to the DVHA's prior authorization requirements. Services requiring prior authorization are found in the Provider Manual. (Medicaid regulatory citations are indicated where applicable):

- inpatient services (rule 7201);

- outpatient services in a general hospital or ambulatory surgical center (rule 7203);
- physician services (rules 7301-7310);
- specialty medical and surgical services of a dentist (rule 7311);
- covered organ and tissue transplants, including expenses related to providing the organ or doing a donor search (rule 7305);
- home health care (rule 7401);
- hospice services by a Medicare-certified hospice provider (rule 7402);
- outpatient therapy services (home infusion therapies and occupational, physical, speech and nutrition therapy) (rules 7203, 7401);
- medical equipment and supplies (rules 7504, 7505);
- skilled nursing facility services (rule 7601);
- podiatry services (rule 7308);

D. Self-Referral Services

The following services may be accessed by beneficiaries without a referral from their primary care provider (PCP):

- unlimited visits per calendar year to a PCCM gynecological health care provider for reproductive or gynecological care, as well as visits related to follow-up care for problems identified during such visits;
- mental health and chemical dependency visits up to benefits of $500 per year. Thereafter, providers must request prior authorization from the department for additional services;
- mental health and chemical dependency services provided by a community mental health center;
- Community Rehabilitation and Treatment Services (CRT);
- one routine eye examination every 24 months (rule 7316) and eyeglasses for children under age 21 furnished through the department's sole source contractor (rule 7316);
- transportation services (rue 7408);
- emergency services (rule 7102.3);
- dental care for children under age 21 (rule 7312) and limited dental services for adults up to an annual benefit maximum (rule 7313);
- chiropractic services (rule 7304);
- maternity/prenatal (rules 7201, 7301);
- family planning services (defined as those services that either prevent or delay pregnancy); and
- personal care services (rule 7406).

E. Cost Sharing

Medicaid beneficiaries age 21 and older are subject to the following co-payment requirements, unless exempt under rules 4161(B):

- $3.00 per day per hospital for hospital outpatient services unless the beneficiary is also covered by Medicare. A beneficiary covered by Medicare has no co-payment requirement for outpatient services.
- $3.00 for each dental visit.
- Prescriptions and durable medical equipment/supplies:
  - $1.00 for each prescription (original or refill) or durable medical equipment/supplies having a usual and customary charge of less than $30.00;
  - $2.00 for each prescription (original or refill) or durable medical equipment/supplies having a usual and customary charge of $30.00 or more but less than $50.00;
  - $3.00 for each prescription (original or refill) or durable medical equipment/supplies having a usual and customary charge of $50.00 or more.

F. Enrollment

1. Choice of Primary Care Provider (PCP)

A benefits counselor will assist beneficiaries in making an informed decision among the choices described in rule 7101, Options 5 and 6.

The benefits counselor will initiate a follow-up contact with a beneficiary who has failed to notify the benefits counselor of his or her decision and will provide additional information if requested to do so. If two or more PCCM PCPs are available and no choice has been made within 30 days of being contacted, the benefits counselor will assign the beneficiary to a PCP using a state-approved algorithm.

2. Change of Primary Care Provider (PCP)

Enrollees may change their primary care provider (PCP) for any reason every 30 days. Primary care provider changes will become effective on the first day of the following month, if all required actions have been completed by the fifteenth of the prior month. Otherwise, the change shall become effective the first of the second month after all required actions are completed.

If a beneficiary has to change PCP as a result of his or her PCP restricting or terminating participation in the PCCM program, the DVHA will assist the beneficiary in selecting another PCP in order to assure continuity of care.

3. Disenrollment

The DVHA has sole authority for disenrolling beneficiaries from the PCCM program. The DVHA may disenroll beneficiaries from the PCCM program for any of the following reasons:

- The beneficiary loses Medicaid eligibility;
- The beneficiary fails to pay required premiums;
- The beneficiary is placed in a nursing facility or ICF-MR for more than thirty (30) days, enrolls in any other state waiver program, enrolls in the department's “High

Tech Home Care" program, or enrolls in Medicare or other comprehensive health insurance plan;

- The beneficiary's change of residence places him or her outside the area where choice of PCCM provider is available, and the beneficiary chooses not to continue enrollment in the PCCM program;
- The DVHA has found that there is a rational and justifiable reason for determining that good cause exists, or upon appeal, the Human Services Board finds good cause exists, as the result of a formal request for disenrollment filed by the beneficiary;
- The DVHA has found that there is a rational and justifiable reason for determining that good cause for disenrollment or transfer to another PCCM provider exists, as the result of a formal request for disenrollment filed with the department by the beneficiary's PCP;
- The DVHA has found that there is a rational and justifiable reason for determining that good cause exists, or, upon appeal, the Human Services Board finds good cause exists; or
- The beneficiary poses a threat to PCCM providers, staff or other beneficiaries.
- The beneficiary regularly fails to arrive for scheduled appointments without canceling, despite documented aggressive outreach efforts by his or her PCP; and
- The beneficiary does not cooperate with treatment and has not made an affirmative decision to refuse treatment, despite documented aggressive outreach efforts by their PCP.

Grounds for disenrollment do not include beneficiaries who have cooperated with their PCP in his/her effort to inform them fully of the treatment options and the consequences of their decisions regarding treatment and who have subsequently made an informed decision to refuse treatment.

The beneficiary will remain enrolled in the PCCM program until the DVHA decides to disenroll or continue the enrollment of the beneficiary. Each beneficiary will be notified of the DVHA's decision in writing and of his/her right to request a fair hearing before the Human Services Board. Beneficiary disenrollments will become effective on an end-of-month basis, but not fewer than five (5) days after the DVHA has made a determination that the beneficiary will be disenrolled.

Beneficiaries who are disenrolled, unless enrolled in a managed health care plan immediately thereafter, will receive services through the fee-for-service system.

4. Conversion of Managed Care Plan Enrollees to the PCCM program

If a beneficiary's delivery system is changed from a commercial managed care plan to the PCCM program, the beneficiary will be assigned to his or her existing PCP. Thereafter, the beneficiary may change his or her PCP according to the provisions of rule 7101.3 F.2.

If the managed care plan members PCP does not participate as a PCP in the PCCM program, the beneficiary will receive covered benefits in the fee-for-service system. The beneficiary's subsequent enrollment in the PCCM program will be deferred for at least six months beyond the date of disenrollment from the managed care plan. The DVHA will make every effort to enroll the beneficiary's provider in the PCCM program prior to the expiration of the enrollment deferral period.

G. Quality Assurance and Utilization Review

1. The DVHA shall ensure that health care services provided to its beneficiaries are consistent with prevailing professionally-recognized standards of medical practice. To that end, the DVHA shall establish and implement procedures ensuring the availability of, accessibility to and continuity of care for each beneficiary consistent with the beneficiary's clinical condition, including procedures for the identification, evaluation, resolution and follow-up of potential and actual problems in their administration and delivery of health care services.

2. The DVHA shall develop and maintain an internal quality assurance program that monitors and evaluates the full range of its health care services across all institutional and non-institutional settings. The quality assurance program shall be fully described in writing and provided to all administrative and clinical staff of the DVHA, and made available to all providers upon request. A summary of the program shall be provided to anyone upon request.

3. The DVHA's quality assurance and utilization management program shall ensure that in making decisions to approve or deny care, it uses not only utilization review standards and guidelines but also clinical case data, information and practice guidelines so as to balance the clinical decision-making process with its cost-containment measures.

4. The DVHA shall have in place the administrative structures, policies, and procedures necessary to support operations that meet the requirements and criteria contained in these rules.

5. The DVHA shall clearly define the organizational relationships and responsibilities for quality assurance functions and assign them to appropriately qualified individuals.

6. The DVHA shall establish effective procedures to develop, compile, and evaluate the statistical and other information necessary to support an effective quality assurance and utilization management program.

7. The DVHA's quality assurance program shall include, but not be limited to, the following components:

   a. A designated committee that is responsible for the DVHA's quality assurance activities. The committee shall include, but not be limited to, at least one beneficiary in the PCCM program and participating providers.

   b. Accountability of the designated committee to the Commissioner of the DVHA through the Medical Director.

   c. Participation in the quality assurance program by the appropriate providers, support staff and beneficiaries. At a minimum, this shall include all PCPs, unless good cause is shown why they should not participate. The DVHA shall establish programs to periodically train such providers, support staff and members to participate meaningfully in the quality assurance program.

   d. Supervision of the quality assurance program by the Medical Director of the DVHA, who shall be a physician licensed in Vermont.

   e. Regularly-scheduled meetings of the designated committee.

f. Minutes or records of the meetings of the designated committee that describe, in detail, the committee's actions, including the problems discussed, recommendations made and any other pertinent information.

H. Quality Management and Improvement

1. The DVHA shall establish an internal system capable of identifying opportunities to improve care. This system shall be structured to identify practices that result in improved health care outcomes, identify problematic utilization patterns, identify those providers that may be responsible for either exemplary or problematic patterns, and foster an environment of continuous quality improvement.

2. The Medical Director shall have primary responsibility for the quality assessment and quality improvement activities required of, and carried out by or on behalf of, the DVHA. The Medical Director shall approve the written quality assessment and quality improvement programs and shall periodically review and revise the program documents and act to ensure their ongoing appropriateness.

3. The DVHA shall use the findings generated by the system to work, on a continuing basis, with network providers and other staff to improve the health care delivered to its beneficiaries.

4. The DVHA shall develop and maintain an organizational program for designing, measuring, assessing and improving the processes and outcomes of health care as identified in its quality improvement program, which shall be under the direction of its Medical Director. The organizational program shall include:

a. A written statement of the objectives, lines of authority and accountability, evaluation tools, including data collection responsibilities, performance improvement activities and an annual effectiveness review of the quality improvement program.

b. An annual written quality improvement plan that describes how the DVHA intends to:

i. analyze both processes and outcomes of care, including focused review of individual cases as appropriate, to discern the causes of variation;

ii. identify the targeted diagnoses and treatments to be reviewed by the quality improvement program each year. In determining which diagnoses and treatments to target for review, the DVHA shall consider practices and diagnoses that affect a substantial number of its beneficiaries or that could place beneficiaries at serious risk. This section shall not be construed to require the DVHA to review every disease, illness and condition that may affect a beneficiary;

iii. use a range of appropriate methods to analyze quality, including:

(A) collecting and analyzing information on over-utilization and under-utilization of services, high-volume and high-risk services, and the continuity and coordination of care for acute and chronically-ill populations;

(B) evaluating courses of treatment and outcomes of health care, including health status measures, consistent with reference data bases such as current medical research, knowledge, standards and practice guidelines; and

(C) collecting and analyzing information specific to a beneficiary or provider or providers, gathered from multiple sources such as utilization management, claims processing, and documentation of both the satisfaction and grievances of beneficiaries;

(D) compare program findings with past performance, as appropriate, and with internal goals and external standards, where available, adopted by the department;

iv. measure the performance of network providers and conduct peer review activities, such as:

(A) identifying practices that do not meet the DVHA's standards;

(B) taking appropriate action to correct deficiencies;

(C) monitoring providers to determine where they have implemented corrective action; and

(D) taking appropriate action when a provider has not implemented corrective action;

v. use treatment protocols and practice parameters developed with the appropriate clinical input and using the evaluations described in paragraphs (i) and (ii) of this subsection (b), or use acquired treatment protocols developed with appropriate clinical input, and give its providers sufficient information about the protocols to enable them to meet the standards established in the protocols;

vi. evaluate access to care for beneficiaries according to standards established in rule 7101.3, including the travel and waiting time standards;

vii. describe the DVHA's strategy for integrating public health and Agency of Human Services goals with the health services offered to beneficiaries, including a description of the DVHA's good faith efforts to initiate or maintain communication with other AHS departments to develop coordinated services for designated populations;

viii. use preventive health services, such as:

(A) adopting practice guidelines specific to preventive health services that are based on reasonable medical evidence;

(B) establishing effective procedures for informing beneficiaries on a continual basis about health promotion and preventive health services available to them; and

(C) assessing its performance in the use of preventive health services;

ix. implement improvement strategies related to program findings;

x. evaluate periodically, but not less than annually, the effectiveness of the strategies implemented in paragraph (ix) of this subsection (b);

xi. ensure that the PCCM providers and beneficiaries have the opportunity to participate in developing, implementing and evaluating the quality improvement system; and

xii. provide beneficiaries the opportunity to comment on the quality improvement process.

I. Utilization Review and Management

1. The DVHA shall be responsible for monitoring all utilization review activities carried out by it or on its behalf and for ensuring that all requirements of this rule and other applicable laws and rules are met.

2. The DVHA will meet the standards established by 18 VSA §9414.

3. The DVHA shall implement a written utilization review program that describes all review activities, both delegated and non-delegated, for services provided to its beneficiaries. The program document shall describe the following:

a. procedures to evaluate whether the requested service is a covered service. In the case of new technology or new application of existing technology, the DVHA has a mechanism to evaluate its inclusion among covered services based on reviews of information from appropriate bodies, using professionals in the process;

b. procedures to evaluate the clinical necessity, appropriateness, efficacy or efficiency of health services;

c. the practice guidelines, data sources and utilization review guidelines used in utilization review decision-making;

d. the process by which individual clinical case data, assessments and information are prospectively, concurrently and retrospectively used together with clinical review criteria and utilization review guidelines in making decisions to approve or deny requested health care services;

e. the criteria used to reach utilization review decisions when individual clinical assessments and utilization review guidelines conflict;

f. the process for conducting reviews of adverse determinations;

g. mechanisms to ensure the consistent application of review criteria decisions that, within the scope of coverage limits, are compatible with the unique needs of each individual patient and each presenting situation;

h. the data collection processes and analytical methods used in assessing the utilization of health care services by its beneficiaries;

i. provisions for ensuring the confidentiality of clinical and proprietary information;

j. the organizational structure (for example, utilization review committee, quality assurance committee, or other committee) that periodically assesses utilization review activities and reports to the DVHA Commissioner; and

k. the staff position functionally responsible for the day-to-day management of the utilization review function.

4. The DVHA's utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to ensure their ongoing efficacy. The DVHA may develop its own clinical review criteria, or it may purchase clinical review criteria from qualified vendors. These criteria shall be periodically reviewed and updated by the DVHA with the involvement of practicing physicians and other health care providers within the PCCM network. The DVHA shall give relevant clinical review criteria to its network providers, and shall make them available to members upon request.

5. The DVHA shall have a registered nurse or physician immediately available by telephone to render utilization review determinations to its providers outside of normal business hours, when such decisions are required to be rendered outside of normal business hours. If urgent care is required outside of normal business hours, the request for authorization must be made on the next business day.

6. With regard to utilization review determinations, the DVHA shall ensure that:

    a. individual clinical case assessments, data and practice guidelines for the relevant clinical conditions are given equal or greater weight than utilization review guidelines in making decisions to approve or deny care, with the former taking precedence over the latter when there is a conflict between the two;

    b. all determinations to deny or limit an admission, service, procedure or extension of stay are rendered by the Commissioner with the advice of the Medical Director. Such determinations shall be made in accordance with clinical and medical necessity criteria established in rules 7102 and 7103 and relevant clinical practice guidelines;

    c. it does not retroactively deny reimbursement for a covered service provided to a beneficiary by a provider who relied upon the written or oral authorization of the DVHA or its agents prior to providing the service to the beneficiary, or for a covered service provided to a beneficiary by his or her primary care provider or a specialist who relied upon the written or oral referral of the primary care provider, except in cases where there was material misrepresentation or fraud; and

    d. all authorizations are confirmed in writing within twenty-four hours of being given in a manner that specifies the services authorized, and are included as part of the beneficiary's records.

7. The DVHA shall issue utilization review decisions in a timely manner pursuant to the requirements of rule 7102.

    a. The DVHA shall obtain all information required to make a utilization review decision, including pertinent clinical information.

    b. The DVHA shall have a process to ensure that utilization reviewers apply clinical review criteria consistently.

8. The DVHA shall routinely assess the effectiveness and efficiency of its utilization review program.

9. The DVHA shall have a data system sufficient to support utilization review program activities and to generate management reports to enable it to effectively monitor and manage health care services provided to its beneficiaries.

10. If the DVHA delegates any utilization review activities to a utilization review organization, the DVHA shall maintain effective oversight of those activities, which shall include:

    a. a written description of the utilization review organization's activities and responsibilities, including reporting requirements;

    b. evidence of formal approval of the utilization review organization program by the DVHA; and

    c. a process by which the DVHA evaluates the performance of the utilization review organization.

11. The DVHA shall coordinate the utilization review program with its other medical management activities, including quality improvement, data reporting, grievance procedures, and processes for assessing beneficiary satisfaction.

12. The DVHA shall provide beneficiaries and providers with access to its review staff by a toll-free number or collect-call telephone line.

13. When conducting utilization review, the DVHA shall collect only the information necessary to perform the function.

14. Compensation to persons providing utilization review services for the DVHA shall not contain incentives, direct or indirect, for those persons to limit access to medically-necessary care. Compensation to such persons may not be based, directly or indirectly, on the quantity or type of adverse determinations rendered.

J. Procedures for Utilization Review Decisions

1. The DVHA shall maintain written procedures for making utilization review decisions and for notifying beneficiaries, representatives of beneficiaries, and providers acting on behalf of beneficiaries of its decisions.

2. For initial and concurrent review determinations, the DVHA shall, within three (3) working days of obtaining all necessary information regarding the admission, procedure or service requiring a review determination, make the determination and notify the treating provider of the determination by telephone. Written confirmation of the determination will be sent to the provider within twenty-four (24) hours of the telephone notification.

    a. In the case of an adverse concurrent review determination, the beneficiary shall not be liable for any services provided before notification to the beneficiary of the adverse determination. Benefits will continue if a fair hearing is requested.

    b. The DVHA shall establish procedures to expedite initial and concurrent review determinations in cases involving urgently-needed care. In no event shall the DVHA take more than twenty-four (24) hours from the time the service is first requested to make an initial or concurrent review determination for such services.

3. The DVHA shall conduct retrospective review determinations consistent with federal requirements.

4. A written notification of an adverse determination shall include the principal reason or reasons for the determination and instructions on how to appeal the determination and how to request additional information. Within 90 days of PCCM program

implementation, the DVHA will add to the written notification, the clinical rationale for the determination including an explanation of the clinical review criteria used to make the determination. The DVHA shall make the actual clinical review criteria available to the beneficiary upon request.

5. The DVHA shall act promptly and in good faith to obtain the information necessary to make utilization review decisions. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

6. The DVHA shall have written procedures to address the failure or inability of a provider or a beneficiary to provide all necessary information for utilization review, which shall include a description of the information required for the review. Copies of the procedures are available to all network providers. In cases where the provider or beneficiary will not release the necessary information, the DVHA may deny certification. In no event shall the DVHA penalize a provider for failing to provide a beneficiary's medical records to the DVHA when the beneficiary has not authorized release of the records and the provider is not otherwise obligated by law or regulation to disclose the records.

K. Fair Hearings, Appeals and Grievances

1. Fair Hearings – Beneficiaries may appeal a denial, reduction or termination of benefits by requesting a fair hearing orally or in writing as specified in rule 4154. Beneficiaries must request a hearing within 90 days of the adverse action. The DVHA shall act on a fair hearing within the time frames specified in the Human Services Board rules found at P2127.

2. Expedited Appeal – Beneficiaries may request an expedited appeal orally or in writing of a denial, reduction or termination of urgent care or emergency services. The DVHA shall respond as expeditiously as the beneficiary's medical condition requires, but in no event more than three (3) days after receipt of the information necessary to resolve the appeal. This shall include any appeal related to whether or not the service in question constitutes emergency services or urgent care. Beneficiaries who are dissatisfied with the resolution of an expedited appeal may continue with the fair hearing process.

3. Grievance – Beneficiaries may file a grievance orally or in writing related to complaints about availability, delivery or quality of health care or about claims payment, handling or reimbursement for health care services. The DVHA shall respond to grievances within thirty (30) days after receipt of the information necessary to resolve the grievance. Grievances that relate to a denial, reduction or termination of benefits may be appealed to the Human Services Board.

4. Guidelines for Fair Hearings, Expedited Appeals and Grievances – Fair hearings shall be conducted pursuant to Human Services Board rules. Expedited appeals and grievances shall be conducted pursuant to the following guidelines:

   a. The person or persons reviewing the expedited appeal or grievance on behalf of the DVHA shall not have been involved with the adverse determination or other issue that is the subject of the hearing, appeal or grievance.

   b. The DVHA shall act promptly and in good faith to obtain the information necessary to resolve the appeal or grievance. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

c. The DVHA shall document its resolution in writing. The resolution shall contain:

- The names and titles of the person or persons reviewing the appeal or grievance on behalf of the DVHA;
- A statement of the reviewer's understanding of the beneficiary's appeal or grievance;
- The reviewer's decision in clear terms, including the basis or other rationale for the decision in sufficient detail for the beneficiary to understand the decision;
- A reference to the evidence or documentation used by the reviewer in making the decision, including clinical review criteria used to make a determination relating to medical care;
- In the case of expedited appeals a notification that the beneficiary may continue with the fair hearing process, if he or she is dissatisfied with the resolution of the expedited appeal.
- The number of the State Health Care Ombudsman.

d. The DVHA shall provide the beneficiary with all the information in its possession or control relevant to the appeal or grievance process and the subject of the appeal or grievance, including applicable policies or procedures and (to the extent applicable) copies of all necessary and relevant medical records. The DVHA will not charge the beneficiary for copies of any records or other documents necessary to resolve the appeal or grievance.

e. For fair hearings and expedited appeals related to medical care, the DVHA shall provide any covered service that had been denied or restricted for which a reversal has been made by its reviewers or by the Human Services Board.

f. If fair hearing or expedited appeal relates to a concurrent review determination for emergency services or urgent care, the service shall be continued without liability to the beneficiary until the DVHA has notified the beneficiary of its final resolution, consistent with fair hearing rules.

5. Appeals Register – The DVHA shall maintain written records documenting all fair hearings, expedited appeals and grievances received during a calendar year (the appeals register). The DVHA shall retain the register compiled for a calendar year for three years. Each register shall contain, at a minimum, the following information:

- The identity of the beneficiary who filed the fair hearing, expedited appeal or grievance, using a unique identification number assigned consistently to that beneficiary;
- A general description of the reason for the fair hearing, expedited appeal or grievance;
- The date the request was received by the DVHA;
- The date of each review and hearing (if any);
- In the case of an expedited appeal, whether the appeal was resolved or went to fair hearing;
- The number of days it took to gather the information necessary to resolve issue and the resolution of the fair hearing, expedited appeal or grievance.

6. Information – The DVHA shall share the information collected by it in its fair hearing, expedited appeal and grievance processes with the persons responsible for its quality assurance, quality improvement and utilization review and management programs.

7. Procedures – The DVHA will maintain procedures by which persons who are unable to file written appeals may notify the department of a grievance or an appeal. The DVHA shall be responsible for documenting such grievances and providing copies to the beneficiaries for their use, or the use of their representatives.

L. Emergency Services

1. Beneficiaries have access to emergency services twenty-four (24) hours per day, seven (7) days per week, while the beneficiary is within the United States at the time such services are needed.

2. The DVHA shall cover emergency services necessary to screen and stabilize a beneficiary and does not require prior authorization of such services.

3. The DVHA will cover urgently-needed care whether the beneficiary is inside or outside of Vermont. Payment for such services will be made by enrolling the provider, if otherwise eligible, in the Vermont Medicaid program.

4. Any provider providing services under this section shall furnish to the beneficiary's primary care provider all relevant and necessary medical information for the beneficiary's ongoing care.

M. Medical Records

1. Medical Records Practices. The DVHA shall work with its PCCM providers to establish, maintain and use a patient record system that will facilitate the documentation and retrieval of statistically-meaningful clinical information, as follows:

   a. Clinical records should be maintained in a manner that is current, detailed and organized and that permits effective beneficiary care and quality review. Records may be written or electronic.

2. Maintenance of Health Care Information; Confidentiality Procedures. The DVHA shall comply with the confidentiality procedures in 33 VSA §111, AHS rule 96.1 and applicable federal law.

N. Provider Agreement

1. The DVHA will not include any provision in the PCCM addendum to the provider agreement that prohibits the health care provider from disclosing to beneficiaries or potential beneficiaries information about the agreement or the beneficiaries' benefit plan that may affect their health or any decision regarding their health.

2. The DVHA shall not prohibit a PCCM PCP from, or penalize a PCCM PCP for, discussing treatment options with beneficiaries regardless of the DVHA's position on the treatment options, or advocating on behalf of beneficiaries within the utilization review or appeals processes established by the DVHA, nor shall it penalize a provider because the provider in good faith reports to state or federal authorities any act or practice by the DVHA that jeopardizes patient health or welfare.

3. The PCCM agreement shall contain provisions clearly stating the requirements and responsibilities of the PCCM program and participating providers with respect to administrative policies and programs, including but not limited to payment terms,

utilization review, quality assessment and improvement programs, grievance procedures, data reporting requirements, confidentiality requirements, and any applicable federal or state requirements. The agreement must allow the provider to participate in the DVHA's quality assurance program, dispute resolution process, and utilization management program.

4. No PCCM agreement shall contain a provision offering an inducement to a provider to forego providing medically-necessary services to a beneficiary.

5. Each PCCM agreement shall contain provisions to ensure the availability and confidentiality of the health records necessary to monitor and evaluate the quality of care, and to conduct medical and other health care evaluations and audits to determine, on a concurrent or retrospective basis, the medical necessity and appropriateness of care provided to beneficiaries. Each provider agreement shall include provisions requiring the provider to make health records available as required by law to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of beneficiaries, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

6. The PCCM provider agreement shall describe a mechanism for informing each provider participating in its PCCM program on an ongoing and current basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on the services.

O. Network Adequacy

1. The DVHA will not require any beneficiary to be assigned to the PCCM program unless covered health care services, including referrals to participating specialty physicians, are accessible to members on a timely basis, as follows. The DVHA will make a good faith effort to attract sufficient numbers and types of providers to ensure that all covered health care services will be provided without unreasonable delay.

   a. Travel time standards. Travel times for PCCM beneficiaries, under normal conditions from their residence or place of business, generally should not exceed the following:

      - thirty (30) minutes to a network primary care provider;
      - thirty (30) minutes to an outpatient facility for mental health or chemical dependency services;
      - sixty (60) minutes for laboratory, x-ray, pharmacy, general optometry, inpatient psychiatric, MRI and inpatient medical rehabilitation services;
      - ninety (90) minutes for cardiac catheterization laboratory, kidney transplantation, major trauma treatment, neonatal intensive care, and open-heart surgery services; and
      - reasonable accessibility for other specialty hospital services, including major burn care, organ transplantation (other than kidneys), and specialty pediatric care.

   b. Waiting time standards. Waiting times for appointments should generally not exceed the following:

      - immediate access to emergency care;

- twenty-four (24) hours for urgent care;
- two (2) weeks for the initial treatment of non-emergency or non-urgent care, with prompt follow-up care as necessary, including referrals for specialty services;
- ninety (90) days for preventive care (including routine physical examinations); and
- thirty (30) days for routine laboratory, x-ray, general optometry, and all other routine services.

c. The DVHA shall develop and implement written standards or guidelines that address the assessment of provider capacity to provide timely access to health care services.

2. The DVHA shall, either directly or through contracts or other arrangements, provide the services of primary care providers sufficient to respond to initial and basic care needs of members. The DVHA shall inform its primary care providers of their responsibility to provide referrals and any specific procedures that must be followed in providing referrals.

3. The DVHA shall permit its beneficiaries to make at least two visits per calendar year to a network gynecological health care provider for reproductive or gynecological care, as well as visits relating to follow-up care for problems identified during such visits, without a referral from the beneficiary's primary care providers. All such visits shall be subject to the utilization review procedures used by the department. A gynecological health care provider providing services under this section shall furnish to the beneficiary's primary care provider all relevant and necessary medical information for ongoing care.

4. The PCPs shall ensure the coordination and continuity of care for their patients. For purposes of this section, “coordination and continuity of care” mean that a beneficiary's health care services are managed by the PCP in a manner that facilitates the treatment of a condition, illness or other medical condition, including all primary care services and any necessary referrals. The DVHA shall establish guidelines for referrals to both participating and non-participating physicians and other providers.

5. The DVHA shall permit certain new members to continue to use their previous providers, so long as those providers agree to abide by the DVHA's payment rates, quality-of-care standards and protocols, and to provide the necessary clinical information to the plan, as follows:

   - new beneficiaries with life-threatening, disabling or degenerative conditions shall be allowed to continue to see their providers for sixty (60) days from the date of enrollment or until accepted by a new provider within the PCCM program, whichever is shorter; and
   - women in their second or third trimester of pregnancy shall be allowed to continue to obtain care from their previous provider until the completion of postpartum care.

6. The DVHA shall establish policies and procedures to ensure the orderly transfer of those beneficiaries whose providers' agreement has expired or been terminated, whether with or without cause, to other health care providers in the PCCM network.

7. The DVHA shall establish policies and procedures through which a beneficiary with a condition that requires ongoing care from a specialist may obtain a standing referral to a participating specialist, subject to the utilization review procedures. For purposes of this provision, “standing referral” means a referral for ongoing care to be provided by

a participating specialist that authorizes a series of visits with the specialist for either a specific time period or a limited number of visits, and which is provided according to a treatment plan developed by the beneficiary's primary care provider, the specialist, the beneficiary and the DVHA.

8. The DVHA shall ensure that beneficiaries may obtain a referral to a health care provider outside of Vermont when a health care provider with appropriate training and experience is not available within Vermont who can meet the particular health care needs of the beneficiary, subject to the utilization review procedures of the DVHA. The beneficiary shall not be responsible for any additional costs incurred by the DVHA under this paragraph other than any applicable cost-sharing.

P. Confidential Information

The DVHA shall take the appropriate steps necessary to ensure that information gathered by it in its quality assurance activities shall be confidential and privileged.

Q. Disclosure of Information

The DVHA shall supply to each beneficiary upon enrollment and upon major revision thereafter the following information. The information shall be in handbook form and in twelve-point type, and shall be in plain language. This requirement may be satisfied by giving a copy of the handbook to each household, rather than to each beneficiary. The DVHA shall make available to any beneficiary, upon request, a listing by specialty of the name, telephone number and address of all health care providers and health care facilities enrolled in PCCM and Medicaid (including, in the case of physicians, information as to board certification). This list shall be updated (by addendum or otherwise) at least once every six months, and shall indicate which primary care providers are accepting new patients. In addition, the handbook shall include:

1. Coverage provisions, including covered health care services and items, benefit maximums, benefit limitations, exclusions from coverage (including procedures deemed experimental or investigational by the DVHA), restrictions on referral or treatment options, requirements for prior authorization or utilization review, the use of formularies, and any other limitations on the services covered.

2. A description of the rule 7104 procedure for coverage of prescription drugs from manufacturers that do not participate in the federal rebate program. In addition to the criteria contained in rule 7104, the DVHA shall also consider the following criteria in making rule 7104 determinations for prescription drugs. The currently covered drug:

   - has not been effective in treating the patient's medical condition; or
   - causes or is reasonably expected to cause adverse or harmful reactions in the beneficiary.

3. If prior authorization or utilization review is required before obtaining treatment or services, the process a beneficiary must use to obtain that authorization or review, including any time lines that apply.

4. The financial inducements offered to any Medicaid provider or health care facility for the reduction or limitation of health care services. Nothing in this paragraph shall be construed to require disclosure of individual contracts or the specific details of any financial arrangement between the DVHA and a health care provider.

5. The beneficiary's responsibility for payment of premiums, coinsurance, co-payments, deductibles and any other charges, annual limits on a beneficiary's financial responsibility,

caps on payments for covered services, and the beneficiary's financial responsibility for non-covered procedures, treatments or services.

6. The beneficiary's financial responsibility for payment when services are provided by a health care provider who is not part of the PCCM network or by any provider after an adverse determination by the DVHA.
7. The criteria used by the DVHA for selecting and credentialing the health care providers it enrolls.
8. The grievance and appeals procedures used to resolve disputes between a beneficiary and the DVHA.
9. A summary of its quality assessment and quality improvement programs.
10. The utilization review procedures of the organization, including the credentials and training of utilization review personnel.
11. The procedure for obtaining emergency services, including any requirements for prior authorization and payment for services rendered outside of Vermont.
12. All necessary mailing addresses and telephone numbers to be used by beneficiaries seeking information or authorization.
13. The process for selecting primary care providers and for obtaining access to other providers in the PCCM network, including any restrictions on the use of network specialists.
14. The procedure for changing primary and specialty care providers within PCCM, including any restrictions on changing providers.
15. How beneficiaries can obtain standing referrals to Medicaid participating specialists, or use specialists or specialized facilities to provide and coordinate their primary and specialty care.
16. The waiting time and travel time standards established in this rule.
17. Whether the health care providers are prohibited from participating in other managed care plans or from performing services for persons who are not members of the PCCM program.
18. Opportunities for beneficiary participation in the development of DVHA policies and in the DVHA's quality assurance and quality improvement activities.
19. The consumer information and services, including the toll-free number for the DVHA Ombudsman.
20. A list of all information available to the beneficiary upon request.

7102 Prior Authorization (04/01/1999, 98-11F)

Prior authorization is a process used by the department to assure the appropriate use of health care services. The goal of prior authorization is to assure that the proposed health service is medically needed; that all appropriate, less-expensive alternatives have been given consideration; and that the proposed service conforms to generally accepted practice parameters recognized by health care providers in the same or similar general specialty who typically treat or manage the diagnosis or condition. It involves a request for approval of each health service that is designated as requiring prior approval before the service is rendered. The department shall notify each patient and provider of its decision, which is arrived at by applying the criteria set forth in rule 7102.2.

"Health services: as used in these rules include services, items or procedures.

7102.1 Criteria for Prior Authorization (04/01/1999, 98-11F)

The department may require prior authorization of payment for a service when one or more of the following criteria are met.

A. The health service is of questionable medical necessity as determined by the department.

B. The department determines that use of the health service needs monitoring to manage the expenditure of program funds.

C. Less expensive appropriate alternatives to the health service are generally available.

D. The health service is investigational.

E. The health service is newly developed or modified.

F. The department determines that monitoring a health service of a continuing nature is necessary to prevent the continuation of the service when it ceases to be beneficial.

The complete and current list of all services and items including procedure codes that require prior authorization is set out in the Provider Manual. The list is updated periodically. Additions and deletions to the list are also published in advance in the provider advisory newsletter and other communications to providers.

7102.2 Prior Authorization Determination (04/01/1999, 98-11F)

A request for prior authorization of a covered health service will be approved if the health service:

A. is medically necessary (see rule 7103);

B. is appropriate and effective to the medical needs of the beneficiary;

C. is timely, considering the nature and present state of the beneficiary's medical condition;

D. is the least expensive, appropriate health service available;

E. is FDA approved, if it is FDA regulated;

F. is subject to a manufacturer's rebate agreement, if a drug;

G. is not a preliminary procedure or treatment leading to a service that is not covered;

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7102.4 **Date of this Memo** 05/01/2008 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Is there a change in the timeframe for processing prior authorization requests?

ANSWER: Yes. The timeframes now correspond to 42 CFR §438.210. OVHA will continue to issue a notice of decision within three days of receipt of all the necessary information. However, the longest time to wait for a decision is now 28 days, not 30. A request must be decided within 14 days of receipt of the request, but that time frame may be extended up to another 14 days if the beneficiary or provider request the extension, or if the extension is needed to obtain additional information and an extension is in the beneficiary's interest.

Also, when a provider indicates, or OVHA determines, that following this timeframe could seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function, OVHA must make an expedited decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than three working days after receipt of the request. This may be extended up to 14 days if the beneficiary so requests, or if the extension is needed to obtain additional information and an extension is in the beneficiary's interest.

H. is not the repair of an item uncovered by Medicaid;

I. is not experimental or investigational;

J. is furnished by a provider with appropriate credentials.

The department is responsible for determining questions of coverage and medical necessity under the Vermont Medicaid program. The department may contract with external organizations to help make these determinations; however, the final decision rests with the department.

Supporting information for a prior authorization request must include a completed claim and a completed medical necessity form. Additional information that may be required includes:

- the patients complete medical record;
- the patients plan of care;
- a statement of long-term and short-term treatment goals;
- a response to clinical questions posed by the department;
- a second opinion or an evaluation by another practitioner, at Medicaid expense;
- the practitioners detailed and reasoned opinion in support of medical necessity;
- a statement of the alternatives considered and the provider's reasons for rejecting them; and,
- a statement of the practitioner's evaluation of alternatives suggested by the department and the provider's reasons for rejecting them.

If any of this additional information is required, the department will notify the provider promptly. Once the necessary information has been received, the beneficiary will be sent a notice of decision that may be appealed. See rule 4151.

7102.3 Waiver of Prior Authorization (04/01/1999, 98-11F)

The department shall waive the requirement that a covered service receive prior authorization if, in the department's judgement, the service provided without prior authorization meets one or both of the following circumstances.

- The service was required to treat an emergency medical condition.
- The service was provided prior to the determination of Medicaid eligibility and within the retroactive coverage period.

7102.4 Prior Authorization Process (04/01/1999, 98-11F)

Prior authorization commences with the receipt of a written prior authorization request. The department will issue a notice of decision within three working days of receiving all necessary information. The department will act in good faith to obtain the necessary information promptly so that it can determine, within 30 days, whether the request may be approved. The department will issue a notice of decision within 30 days of receiving the initial prior authorization request, even if all necessary information has not been received.

Medical Necessity

7103 Medical Necessity (04/01/1999, 98-11F)

“Medically necessary” means health care services, including diagnostic testing, preventive services, and aftercare, that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the beneficiary's diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition, and

A. help restore or maintain the beneficiary's health; or

B. prevent deterioration or palliate the beneficiary's condition; or

C. prevent the reasonably likely onset of a health problem or detect an incipient problem.

Additionally, for EPSDT-eligible beneficiaries, medically necessary includes a determination that a service is needed to achieve proper growth and development or prevent the onset or worsening of a health condition.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7104 **Date of this Memo** 07/01/1999 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Can a traditional Medicaid beneficiary request coverage of a brand-name prescription drug that is presently not available because the manufacturer does not participate in the Federal Drug Rebate Program through the rule 7104 Procedure?

ANSWER: Yes. On July 1, 1999, additional criteria were adopted for the rule 7104 Procedure. The following criteria will be taken into account when reviewing requests for prescription drugs not on a list pre-approved for coverage because the drug manufacturer does not participate in the Federal Drug Rebate Program. If the currently covered drug:

A. has not been effective in treating the patient's medical condition; or

B. causes or is reasonably expected to cause adverse or harmful reactions in the beneficiary.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically superseded–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7104 Date of this Memo 4/1/2015 Page 1 of 1
This Memo: [ ] is New [X] Replaces one dated 10/1/2014

QUESTION: Were there any negotiated settlements, decisions reversed by the Human Services Board, Vermont Supreme Court, or favorable rulings from April 1, 1999 through April 1, 2015?

ANSWER: A chart with all 7104 approvals can be found here: http://dvha.vermont.gov/budget-legislative/approved-latest.pdf

7104 Requesting Coverage Exceptions (04/01/1999, 98-11F)

Any beneficiary may request that the department cover a service or item that is not already included on a list of covered services and items. The request should be sent to the Director of the Office of Vermont Health Access (OVHA). The director will review the request and supporting documentation and make a good faith effort to obtain any additional information quickly to allow the commissioner to make a decision within thirty days. In no case will a request for a service or item be approved for coverage unless it is medically necessary.

Each decision shall result in one of four outcomes. The four possible outcomes are: (1) the commissioner approves coverage of the service or item for the individual and adds it to a list of pre-approved services or items; (2) the commissioner approves coverage of the service or item for the individual and does not add it to a list of pre-approved services or items; (3) the commissioner does not approve coverage of the service or item for the individual and adds it to a list of pre-approved services or items; or (4) the commissioner does not approve coverage of the service or item for the individual and does not add it to a list of pre-approved services or items.

If the commissioner's decision is to add the service or item to a pre-approved list of covered services, an Interpretive Memo will be issued delineating the addition. All such Interpretive Memos will be incorporated into the rule as soon as practical. An adverse decision from the commissioner may be appealed through the fair hearing process. An adverse decision may not be renewed by the same beneficiary until twelve months have elapsed since the previous final decision or until new documentation of the individual's condition, a change in the individual's condition, new medical evidence, or a change in technology has been demonstrated.

The Office of Vermont Health Access shall, semiannually, issue an Interpretive Memo updating the listing of all affirmative coverage decisions made under this procedure that do not result in the service or item that is authorized being added to a list of pre-approved services or items. This list shall include the commissioner's coverage decisions, plus negotiated settlements and Human Services Board and Vermont Supreme Court decisions. Because this list shall be available for public inspection, it shall be composed in a manner that protects beneficiaries right to confidentiality. The department will ensure that all Medicaid beneficiaries who are similarly situated to the individual who has obtained coverage will be treated similarly with respect to coverage of the same service or item.

If, under this section, an individual requests that a service or item be covered, the following criteria will be considered, in combination, in determining whether to cover the service or item for the individual and/or to add it to a list of pre-approved services or items, with the following exception. If the service or item is subject to FDA approval and has not been approved (criterion (I) below), the request for coverage of the service or item will be denied.

A. Are there extenuating circumstances that are unique to the beneficiary such that there would be serious detrimental health consequences if the service or item were not provided?

B. Does the service or item fit within a category or subcategory of services offered by the Vermont Medicaid program for adults?

C. Has the service or item been identified in rule as not covered, and has new evidence about efficacy been presented or discovered?

D. Is the service or item consistent with the objectives of Title XIX?

E. Is there a rational basis for excluding coverage of the service or item? The purpose of this criterion is to ensure that the department does not arbitrarily deny coverage for a service or item. The department may not deny an individual coverage for a service or item solely based on its cost.

Requesting Coverage Exceptions

F. Is the service or item experimental or investigational?

G. Have the medical appropriateness and efficacy of the service or item been demonstrated in the literature or by experts in the field?

H. Are less expensive, medically appropriate alternatives not covered or not generally available?

I. Is FDA approval required, and if so, has the service or item been approved?

J. Is the service or item primarily and customarily used to serve a medical purpose, and is it generally not useful to an individual in the absence of an illness, injury, or disability?

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7105 Date of this Memo 09/01/2013 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

QUESTION: Have there been any changes to Medical Service Payments?

ANSWER: Yes. On at least a quarterly basis, the DVHA, instead of its fiscal agent, sends a notice of Medicaid benefits paid to a sample of beneficiaries who received a service during that quarter.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7105.1 Date of this Memo 05/01/2012 Page 1 of 1
This Memo: [ ] is New [X] Replaces one dated 04/01/2008

QUESTION: The rule at 7105.1 (H.) says that we do not cover items and services covered by private health insurances. Do we cover items and services if the other insurance has denied them?

ANSWER: We consider coverage under Medicaid rules if the other insurance denies because the item or service is not included in the coverage contract, is non-covered, or benefits are exhausted.

If the other insurance has denied for a reason other than not included in the coverage contract, non-covered, or benefits exhausted, the beneficiary or provider must first go through all required levels of the insurance plan's appeal process, as well as the external review from the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA), if eligible and available. If the billed amount is less than $100, BISHCA will not hear the appeal so the final insurance plan appeal is sufficient (mental health appeals do not have the $100 threshold). The beneficiary must meet the timeframes specified by BISHCA for the external appeal.

Medicare beneficiaries or their providers must appeal through the Qualified Independent Contractor level prior to requesting that Medicaid cover the service or item.

If these appeals are all denied, the beneficiary's provider may ask Medicaid to make an independent assessment of coverage and medical necessity and, if approved, cover the item or service. The Medicaid decision will be based on the same documentation submitted for the previous appeals.

For beneficiaries covered by Medicare, the requirement to go through the Medicare Qualified Independent Contractor appeal level applies with the exception of wheelchairs that Medicare denies or downgrades. Upon documentation of the Medicare action, Medicaid will make its own medical necessity and payment determination.

7105 Medical Service Payments (04/01/2005, 05-09)

The department pays providers for Medicaid Services through a fiscal agent. To receive payment, the provider must send a claim to the fiscal agent subject to the limitations and conditions specified in rules 7105.2-7108.3.

The department will reimburse a Medicaid recipient for his/her out-of-pocket expense for covered medical services under the following conditions only:

- The recipient applied for benefits after February 15, 1973, and was denied; and
- The recipient was later granted Medicaid as a result of any review of the initial denial which resulted in its reversal (e.g. quality control review, supervisory review, SSI appeal, appeal and reversal by the Human Services Board, or any other identification of an error in the original determination which results in its reversal).

Reimbursement is for 100 percent of the out-of-pocket expenditures made by a recipient or a member of his/her Medicaid group or a financially responsible relative who is not a member of the group, for Medicaid-covered services provided between the date of eligibility (which may be as early as the first day of the third month before the month of application) and the date the recipient's first Medicaid ID was made available to him/her (when this date cannot be determined otherwise, use the second mail delivery day following the date the first Medicaid ID was mailed). No copayment is due.

Payment cannot otherwise be made direct to a Medicaid recipient, even if he/she has already paid the provider for a covered service. When Medicaid coverage is granted after bills have been paid (for example, through application for retroactive coverage), the recipient may ask the provider to bill Medicaid and refund the recipient's payment. If the provider agrees to do so, he/she must accept the Medicaid allowance and refund the full amount of the recipient's payment (see also Provider Responsibility).

The fiscal agent sends a notice of Medicaid benefits paid to a sample of recipients who receive a service each month. The recipient must report any disagreement with the notice to the department.

7105.1 General Exclusions (02/01/2003, 02-33)

No payment will be made for certain items and services including the following:

A. Items and services not reasonable and necessary for the treatment or diagnosis of illness or injury, or to improve the functioning of a malformed body member.

B. Items for which neither the beneficiary nor any other person or organization has a legal obligation to pay. This exclusion applies, for example, to X-rays or immunizations provided without charge to the general public by a health organization.

C. Items and services furnished, paid for or authorized by an entity of the Federal Government.

D. Care and services provided in a foreign country, except as provided in Medicare regulation 42 CFR 424 Subpart H, which allows payment for emergency inpatient hospital care and related ambulance and physicians services if the following conditions are met:

- The beneficiary was present in the U. S. when the emergency arose, or was traveling to Alaska by the most direct route without delay, and

- The foreign hospital is closer to, or more accessible from the site of the emergency than the nearest U. S. hospital equipped to deal with and available to treat the individual's illness or injury.

E. Care and services ordered or prescribed by an immediate relative (see F) of the beneficiary.

F. Care and services furnished by an immediate relative of the beneficiary or by a facility, such as a nursing home, of which an immediate relative is owner or principal stockholder. For purposes of this section, "immediate relative" includes spouse; natural parent, child, and sibling; adopted child and parent; stepparent, stepchild, stepbrother and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law and sister-in-law; grandparent and grandchild.

G. Items and services to the extent that payment has been or can be expected to be made under worker's compensation.

H. Items and services covered by private health insurances.

I. Items and services ordered by an individual not enrolled as a Medicaid provider.

J. Premiums for health insurance plans when the department has not required the beneficiary to enroll or remain enrolled.

K. Preliminary procedures or treatments leading to a service that is not covered by Medicaid.

L. Repair of items not covered by Medicaid.

7105.2 Provider Responsibility (07/01/1991, 91-31)

In order to assure the highest quality medical care and services, Medicaid payments are made only to providers meeting established Medicaid standards. Providers who are certified for participation in Medicare are automatically approved for Medicaid participation, providing no sanction has been imposed as provided in Violations of Provider Responsibility. Comparable standards for providers who do not participate in Medicare are established by State law and appropriate licensing and standard-setting authorities in the respective health and mental health fields. Additional specific requirements by provider type are contained in rules 7201-7608.

Payment for covered services under Medicaid is limited to those services certified as medically necessary in the judgment of a qualified physician for the proper management, control, or treatment of an individual's medical problem and provided under the physician's direction and supervision.

Providers agree to keep necessary records as required by Medicaid regulations and make them available to authorized State and Federal officials upon request.

Medicaid payment rates are established for covered services. For certain services, a recipient copayment may be required for a portion of the Medicaid rate (see Obligation of Recipients).

A provider must accept as payment in full the amounts paid in accordance with the rate schedule established for Medicaid. For example, a physician performing a particular surgical procedure may not request or receive any additional payment from the recipient, or anyone acting on the recipient's behalf, for the same surgical procedure, although in medical expenses spend-down cases, as specified by the Department for Children and Families, Economic Services Division, the recipient may be held responsible for a portion of the amount specified in the fee schedule (see rules 4400-4474.4).

No Medicaid payment will be made for claims received either by the Department or its fiscal agent later than six months following the date the service was provided, except when the delay has been caused by extenuating circumstances and authorization has been granted by the OVHA.

When the recipient has other medical insurance, the benefits available must be applied prior to payment by Medicaid. In instances where other insurance companies have been billed, but not paid, claims may be submitted up to 12 months from the date of service.

In no case will payment be made when more than 24 months have elapsed since the date of service. A provider must, as well, meet other commonly accepted standards of professional practice, including compliance with State and Federal anti-discrimination regulations.

In all joint Medicare-Medicaid cases the provider of services must accept assignment of Medicare payment in order to receive payment from Medicaid of amounts not covered by Medicare.

Claims and claims documentation as required must be submitted in a form acceptable to the OVHA or its designee.

7105.3 No Reassignment of Claims (12/01/1980, 80-62)

No payment for any care furnished to a recipient will be made to anyone other than the provider except that payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order (see also appeal process exception - rule 7105).

With respect to physicians, dentists, or other individual practitioners payment may be made:

To the employer, if the practitioner is required as a condition of his employment to turn over his fees to his employer; or

To the facility in which the care or service was provided, if there is a contractual arrangement between the practitioner and that facility whereby the facility submits the claims for reimbursement; or

To a foundation, plan, health maintenance or similar organization, which furnishes health care through an organized health care delivery system if there is a contractual arrangement between the organization and the person furnishing the service under which the organization bills or receives payments for such person's services.

Payment will not be made to or through a factor, making claim by virtue of a power of attorney, sale, assignment or other transfer given by the provider to the factor. In this context a "factor" is an organization, collection agency, service bureau, or an individual that receives an added fee or a deduction of a portion of the face value of the accounts receivable in return for advancing money to a provider for his accounts receivable.

7106 Violations of Provider Responsibility (04/01/1999, 98-11F)

Information from any source indicating that a provider is violating any of the policies set forth above shall be transmitted to the department. The following describes the administrative actions and sanctions that the department may take with regard to any provider participating in the Vermont Medicaid program. Taking these actions, however, does not preclude subsequent or simultaneous civil or criminal court action.

7106.1 Definitions (04/01/1999, 98-11F)

"Provider" means any individual, firm, corporation, association or institution that is currently approved to provide medical assistance to a beneficiary pursuant to the Vermont Medicaid Program.

"Person" means any natural person, company, firm, association, corporation or other legal entity.

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

"Administrative Agent" means an organization that processes and pays provider claims on behalf of the department.

"Review Methods" means the methods by which the department or its administrative agent determines whether payment errors have been made.

"Exclusion from participation" means termination of a provider's participation in the Vermont Medicaid Program, with the probability that it is permanent.

"Suspension from participation" means temporary expulsion from participation in the Vermont Medicaid Program for a specified period of time or until specified conditions are met.

"Deferment of payments" means the withholding of payments due a provider pending resolution of a specified problem. It may be taken or continued as a sanction or imposed as an administrative precaution upon discovery of a provider discrepancy.

"Offsetting of payments" means a reduction or other adjustment of the amounts paid to a provider on deferred, pending, or future bills for purposes of recovering over-payments previously made to the provider.

"Closed-end Medicaid provider agreement" means an agreement that is for a specified period of time not to exceed twelve months.

"Open-end Medicaid provider agreement" means an agreement that has no specific termination date and continues in force as long as it is agreeable to both parties.

7106.2 Grounds for Sanctioning Providers (04/01/1999, 98-11F)

Sanctions may be imposed by the department against a provider for one or more of the following reasons.

A. Presenting or causing to be presented for payment any false or fraudulent claim for care or services.

B. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

C. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

D. Submitting a false or fraudulent application to obtain provider status.

E. Failing to disclose or make available to the department or its authorized agent records of services provided to Medicaid beneficiaries and records of payments received for those services.

F. Failing to provide and maintain services to Medicaid beneficiaries within accepted medical community standards as adjudged by a body of peers.

G. Failing to comply with the terms of the provider certification agreement that are printed on the Medicaid claim form.

H. Over-utilizing the Medicaid program by inducing, furnishing or otherwise causing a beneficiary to receive care and services not required by the beneficiary.

I. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral.

J. Conviction of a criminal offense related to the practice of medicine resulting in death or injury to one or more patients.

K. Failing to meet and maintain substantial compliance with all State and Federal regulations and statutes, applicable to the provider's profession, business or enterprise.

L. Termination or suspension from participation in Medicare.

M. Suspension or termination from participation in other State or Federal programs such as Maternal and Child Health, etc.

N. Documented practice of billing or collecting from the beneficiary an amount in addition to that received from Medicaid for that care or service.

O. Failing to correct deficient provider operations after receiving written notice of these deficiencies from the department, other responsible State agencies, or their designees.

P. Formal reprimand or censure by an association of the provider's peers for unethical practices.

Q. Failure to change or modify delivery patterns for care and services within a reasonable period from receipt of a request to do so by a peer review committee whose composition includes representation of the provider's peers.

R. Presenting or causing to be presented for payment a disproportionate number of claims which are rejected or denied due to submission errors made by the provider or his or her agent. In this context disproportionate is determined in relation to providers of similar services.

S. Being convicted under any law relating to the Medicaid program or under any law of general applicability for acts arising out of the Medicaid program.

7106.3 Sanctions (04/01/1999, 98-11F)

One or more of the following sanctions may be invoked against providers based upon the grounds specified in rule 7106.2:

- exclusion from participation in the Medicaid program;
- suspension from participation in the Medicaid program;
- deferment or offsetting of payments to a provider;
- transfer to a closed-end provider agreement not to exceed 12 months;
- mandatory attendance at provider information sessions;
- required prior authorization of service;
- 100 percent review of the provider's claims prior to payment; or
- recovery of overpayment by offset or civil action, including recovery of reasonable interest and costs.

7106.4 Imposition and Extent of Sanctions (04/01/1999, 98-11F)

When the staff of the department determines that grounds exist and a provider sanction is being considered the department will advise the provider in writing, of the discrepancy noted. The contact with the provider will set forth in the case of mandatory sanctions (rule 7106.4.3), the extent and reason for the sanction, or in cases of discretionary sanctions:

- the nature of the discrepancy or inconsistency;
- the dollar value, if any, of such discrepancy or inconsistency;
- the method of computing such dollar values;
- that one or more sanctions may be taken;
- that the provider may, within 20 days from receipt of written notice, request a meeting with the Director of the OVHA to negotiate an amicable settlement of the discrepancy or request a commissioner's conference to be heard in the matter;
- that the provider may bring evidence, witnesses and representation of choice to either the meeting or conference as desired, or may submit a written statement to the Director or Commissioner for consideration in the decision to impose sanction; and
- that if a meeting or conference is not requested within the 20-day period, the decision regarding imposition of sanctions will be made based upon information at hand.

Simultaneous with taking action to advise the provider as above, the department may defer payments on pending and future claims pending resolution of the discrepancy and shall so advise the provider if this action has been taken.

If a mutually agreeable settlement is negotiated with the Director of the OVHA, formal sanction action is discontinued at this point. If not, at any point in the negotiation, at the discretion of either party, a commissioner's conference may be requested to resolve the issue.

If the provider prefers to bypass negotiation with the director and, within 20 days from receipt of written notice, does request a commissioner's conference in the matter at dispute, or negotiations are unsuccessful and a conference is requested, a date shall be set, with notice sent to all parties, and the conference conducted within 20 days from the date of request. The purpose of the conference shall be to assure that the commissioner has all pertinent information at hand prior to making a decision regarding imposition of sanctions. The provider may utilize any records, witnesses, or other information which will be helpful in achieving this purpose and may utilize legal or other representation in the presentation. The conference will be recorded and pertinent records retained by the department at least until the end of the appeal period, and if subsequent imposition of sanction is appealed, shall be made available to all parties as potential evidence in the conduct of the appeal hearing. If, after written notice as provided above, there has been no request from the provider for either a director's meeting or commissioner's conference at the end of 10 days, this shall be noted and the commissioner shall proceed, on the basis of information at hand, to imposition of sanctions as outlined in following sections.

7106.4.1 Imposition of Sanctions

The decision as to discretionary sanctions to be imposed shall be made by the commissioner.

The following factors shall be considered in determining discretionary sanctions to be imposed:

- seriousness of the offense,
- extent of the violations,
- history of prior violations,
- prior imposition of sanctions,
- prior provision of provider information and training,
- provider willingness to adhere to program rules,
- agreement to make restitution,
- actions taken or recommended by peer groups or Licensing Boards, and
- whether a lessor sanction will be sufficient remedy.

The following mandatory sanctions shall be applied by the commissioner effective as of the date of action requiring the sanction.

- When a provider has been suspended or terminated from the Medicare program, imposition of the same sanction as that imposed by Medicare is mandatory upon the commissioner by federal regulation. The only appeal is to the Medicare sanctioning authority.
- When a provider has been convicted of a violation under 33 VSA Chapter 26, Subchapter 5 or under any Vermont statute of general applicability, and said conviction arises from or is directly related to the Medicaid program (33 VSA Ch 36), that provider will be suspended from further participation in the Medicaid program for a period of four years unless such suspension is specifically waived or reduced by the Secretary of Human Services.
- When a provider has failed to retain licensure, certification or registration which is required by state or federal law for participation in the Medicaid program, suspension from participation shall be imposed.

7106.4.2 Scope of Sanctions

A sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case by case basis after giving due regard to all relevant facts and circumstances. The violation, failure or inadequacy of performance may be imputed to a person with whom the provider is affiliated where such conduct was accomplished within the course of his or her official duty or was effectuated by him or her with the knowledge or approval of such person.

Suspension or exclusion from participation of any provider shall preclude such provider from submitting claims for payment, either personally or through claim submitted by any clinic, group, corporation or other association to the department or its fiscal agent for any services or supplies provided under the Medicaid program except for those services or supplies provided prior to the effective date of the suspension or exclusion.

No clinic, group, corporation or other organization which is a provider of services shall submit claims for payment to the department or its administrative agent for any services or supplies provided by a person within such organization who has been suspended or excluded from participation in the Medicaid program except for those services and supplies provided prior to the effective date of the suspension or termination.

When any provision of rule 7106.2, above is violated by a provider of services which is a clinic, group, corporation or other organization, the department may suspend or terminate such organization or any individual within said organization who is responsible for such violation.

7106.4.3 Notice of Sanctions

When a provider has been sanctioned, the commissioner or the commissioner's designee shall notify the provider in writing of the sanction imposed. The letter will also notify the provider of his right of appeal. The provider shall also be notified when a decision is made to take no sanctions.

When a provider has been sanctioned, the commissioner shall notify as appropriate, the applicable professional society, Board of Registration or Licensure, and federal or state agencies of the findings made and the sanctions imposed.

When a provider's participation in the Medicaid program has been suspended or terminated, the commissioner may notify the beneficiaries for whom the provider has submitted claims for services, that such provider has been suspended or terminated.

7106.5 Provider Information Program (04/01/1999, 98-11F)

When the sanction of mandatory attendance at provider information programs is a condition of continued participation, the department will notify the provider of time, date and place. These sessions may be scheduled as group sessions or as individual sessions at the discretion of the department and may include voluntary attendees as well as those required to attend under sanction.

Provider Information Programs may include instructions relating to:

- claim form completion,
- use and format of provider manuals,
- use of appropriate procedure codes,
- key provisions of the Medicaid program,
- reimbursement rates and billing charges, and

- how to inquire about coding or billing problems.

7106.6 Right of Appeal (04/01/1999, 98-11F)

The rights of appeal from mandatory sanctions are limited to the appeal rights inherent in the originating authority; i.e., the Medicare sanctioning authority, the courts, or licensing authority as appropriate to the cause for sanction.

A provider may appeal a discretionary sanction within 10 days after notice of such sanction by requesting a hearing of the Secretary of the Agency of Human Services. Unless a timely request for hearing is received by the Secretary, the sanctions shall be considered final and binding. The sanctions imposed shall be suspended pending the outcome of the hearing; however, if payment on pending and future claims has been deferred pending resolution of the discrepancy, such deferment shall be continued.

A hearing on the appeal shall be conducted within 30 days of the request, by the Secretary or a hearing officer appointed by the Secretary, under the same rules of conduct as in current use for hearings before the Human Services Board.

7106.7 Withholding Payments (04/01/1999, 98-11F)

In accordance with 42 C. F. R. 455.23, the department may withhold payment, in whole or in part, to a provider upon receipt of reliable evidence that; grounds for sanctioning a provider may exist as set forth in rule 7106.2. The Medicaid Fraud and Residential Abuse Unit (MFRAU) of the attorney general's office will review the evidence and determine whether there are reasonable grounds to believe that fraud or willful misrepresentation has occurred. If the MFRAU determines that reasonable grounds exist then the department may withhold payments without first notifying the provider of its intention to withhold such payments.

The department shall send notice of its decision to withhold program payments within five days of taking such action. The notice must set forth the general allegations that form the basis of the withholding action. The notice shall also:

- state that payments are being withheld in accordance with this provision;
- state that the withholding is for a temporary period as stated in this section, and cite the circumstances under which withholding will be terminated;
- specify which Medicaid claims are affected by the withholding action; and
- inform the provider of the right to submit to the commissioner written evidence contradicting the allegations which formed the basis for the withholding action.

Within ten days, the commissioner shall review the evidence submitted by the provider and determine whether the withholding of payments by the department under this section is warranted.

All withholding of payment actions under this section will be temporary and will not continue after:

- the department and the Medicaid Fraud and Residential Abuse Unit of the Vermont Attorney General's Office determine that there is insufficient evidence of fraud or willful misrepresentation by the provider; or

- legal proceedings related to the providers alleged fraud or willful misrepresentation are completed.

The procedures relating to sanctions under the Medicaid program as delineated in rules 7106.4–7106.6 shall not apply during the period of any withholding action under this section.

7107 Utilization Control (12/01/1980, 80-62)

The Department in accordance with 1902 (a) (30) of the Social Security Act, has implemented a statewide utilization control program to safeguard against unnecessary or inappropriate utilization of services available under Medicaid. Excessive or inappropriate use of service is identified through the utilization review process and characterized as recipient abuse, provider abuse, or a combination thereof. Reports of suspected abuse generated by Department staff, the medical community or the general public should be referred to the OVHA.

7107.1 Beneficiary Abuse (12/01/1980, 80-62)

When recipient abuse is identified, the recipient's access to care will be limited through a requirement for prior authorization, restriction to selected providers, or other appropriate action. Instances of recipient abuse include, but are not limited to:

Obtaining an inordinate supply of a prescription drug, especially those which are potentially addictive; or

Consistently requesting care at a hospital emergency facility for non-emergency ailments; or

Obtaining concurrent service from two or more practitioners for the same condition without medical referral, on an ongoing basis or for purpose of obtaining prescriptions necessary for the implementation of (i) above. This is not to preclude reasonable access to a "second opinion" of a diagnostic nature or taking action on such opinion.

7107.2 Provider Abuse (12/01/1980, 80-62)

When provider abuse is identified it may result in denial of payment, taking administrative action as provided in rule 7106, or the initiation of civil or criminal fraud action. Examples of provider abuse include, but are not limited to:

Inducing, furnishing or otherwise causing a recipient to receive service not required for the recipient's care; or

Submission of incorrect claims; or

Excessive prescribing or dispensing of drugs, especially those which are potentially addictive or which are essentially irrelevant to the patient's care other than for their placebo effect.

7108 Third Party Liability (02/01/2003, 02-33)

Medicaid is the payer of last resort, after all third party medical resources have been applied. A third party is defined as one having an obligation to meet all or any portion of the medical expense incurred by the beneficiary for the time such service was delivered. Such obligation is not discharged by virtue of being undiscovered or undeveloped at the time a Medicaid claim is paid; it then becomes an issue of recovery (see rule 7108.2). Medicaid beneficiaries are required to follow all rules of their third party insurance. Medicaid will not pay claims that have been denied by the third party insurer for failure to follow their rules. Some examples of third party medical resources are:

- Medicare;
- Health insurance, including health and accident but not that portion specifically designated for "income protection" which has been considered in determining beneficiary eligibility to participate in the Medicaid program;
- Medical coverage included in conjunction with other benefit or compensation programs such as military and veteran programs, and worker's compensation; and
- Liability for medical expenses as agreed or ordered in negligence suits, support settlements, trust funds, etc.

7108.1 Health Insurance Premiums (02/01/2003, 02-33)

The commissioner may elect at any time to require an applicant or beneficiary to enroll, or remain enrolled, in a private health insurance plan, provided that such enrollment meets the conditions specified in this section and in rule 4138.4 and, in the commissioners judgment, is likely to be cost-effective and in the department's best interest. If enrollment is required, the department will pay the individual's share of the health insurance premium.

Once an individual has met this requirement by enrolling or remaining enrolled in a health insurance plan, Medicaid will cover the full array of Medicaid services and items, provided that the rules of their health insurance plan have been followed.

7108.2 Adjustment or Recovery (02/01/2003, 02-33)

The department may take action either before or after Medicaid payment of a claim to assure appropriate disbursement of Medicaid funds when payment turns out to be inappropriate due to subsequently discovered resources, fraud, error, or the development of third party-liability. Taking administrative action and accepting partial or full reimbursement shall not preclude either simultaneous or subsequent action in civil or criminal court as appropriate.

The department may:

A. negotiate adjustment or recovery on a voluntary basis with recipient, provider, or an obligated third party;

B. accept adjustment or recovery in conjunction with the imposition of provider sanctions (see rule 7106.4);

C. file a lien against any third party to recover Medicaid expenditures from any settlement, judgment, or other income that may be awarded through negligence liability action;

D. enter direct civil action to effect adjustment or recovery when other efforts fail; or

E. investigate and prepare for referral to the appropriate criminal prosecutor any case presumed subject to adjustment or recovery by way of such action.

Providers may be required to enter a claim against any subsequently discovered health insurance resources previously unknown or overlooked and submit an adjusted Medicaid claim upon collection, with reimbursement as appropriate.

7108.3 Estate Recovery (02/01/2003, 02-33)

The department shall seek adjustment or recovery from the estates of individuals who died on or after January 1, 1994 provided that the individuals were 55 years of age or older when they received long-term care services paid for by the Medicaid program for nursing facility services, home-and-community-based waiver services, and related hospital and prescription drug services. Related hospital and prescription drug services are those paid for by the Medicaid program during a period of time when the individual is living in a nursing facility or enrolled in a home-and-community-based waiver program. Adjustment or recovery shall include amounts in personal needs accounts.

The department will file a claim with the probate court as a creditor of the estate to recover its expenditures for long-term care services only after the death of an individual's surviving spouse, if any, and when the individual has no surviving child who is under age 21, or blind, or permanently and totally disabled as defined by the Social Security Administration.

7108.3.1 Exemptions from Estate Recovery

The department exempts the following assets from estate adjustment or recovery when an heir requests an exemption in writing no later than four months after the publication of notice to creditors of the estate.

A. Homes in trust prior to December 1, 1997:

The department normally recovers for long-term care Medicaid costs incurred after January 1, 1994. Individuals with homes in revocable trusts who received Medicaid payment of long-term care services before December 1, 1997, however, are exempt from recovery until after May 1, 1998, or, if later, the effective date of the first Medicaid eligibility review completed after December 1, 1997.

B. When loss of assets would present an undue hardship:

The department will not seek adjustment or recovery from assets when that adjustment or recovery would present an undue hardship to the decedents family members, as specified below and in rule 7108.3.

1. Income-producing assets

Undue hardship exists when adjustment or recovery from an income-producing asset can be made only if the asset, alone or in combination with other related assets, is sold and either or both of the following conditions are met:

a. The assets sold are the sole source of income for the decedents spouse, parents, children, or siblings.

b. As a result of the sale, the decedents spouse, parents, children, or siblings would qualify for public assistance (Reach Up benefits, SSI/AABD, general or emergency assistance, or TANF or TANF/MOE benefits from another state).

C. Estates with personal property valued at less than $2,000:

The department will not seek recovery where the estate inventory filed with the probate court consists only of personal property that does not exceed $2,000 in value, such as home furnishings, apparel, personal effects, and household goods.

The department will not seek to recover assets for which the department has imposed a penalty period of ineligibility for Medicaid coverage of long-term care services related to the transfer of those assets.

7108.3.2 Hardship Exemptions for Homesteads

At any time before closure of the probate estate, an heir may assert that adjustment or recovery against the homestead would be an undue hardship and that the homestead should be exempt from adjustment or recovery for the costs of Medicaid long-term care services. The department shall exempt a decedents home from estate adjustment or recovery based on undue hardship when one or more of the following three conditions have been established to the departments satisfaction.

A. A sibling has been living in the home continuously for at least one year immediately before the date the decedent began receiving long-term care services.

B. A son or daughter has been living in the home continuously for at least two years immediately prior to the date the decedent began receiving long-term care services and provided care that allowed the decedent to remain at home.

C. Conditions (1), (2), and (3) below have been met.

1. The fair market value of the homestead is less than $250,000. If the fair market value of the homestead exceeds this amount, the first $250,000 in fair market value shall be exempt from estate recovery and any equity value in excess of $250,000 shall be subject to the provisions of rule 7108.3.

2. A sibling or lineal heir of the deceased Medicaid beneficiary will inherit the homestead. A lineal heir is a direct descendant, such as a child or grandchild.

3. The heir meets one or both of conditions (a) and (b) below.

a. The heir has gross family income below 300 percent of the federal poverty level. No income exclusions or deductions are allowed. The income of the persons presented in the following table is included in the heirs gross family income, provided that they are living in the heirs household.

Heir's Household

Type of Heir	Family Members, If Living in the Heirs Household
Adult 18 years or older; or person younger than 18 and emancipated	Heir Heirs spouse or civil union partner Heirs biological or adoptive child or stepchild
Person younger than 18 and not emancipated	Heir Heirs parent Heirs stepparent Heirs biological or adoptive sibling, stepsibling, or half sibling, if younger than 18 and not emancipated

b. The heir demonstrates that significant services or financial support provided to the deceased person by heirs meeting condition (2) or the spouses of such heirs enabled the person to avoid long-term care or delay it at least six months. It is not necessary for the deceased person to have been a Medicaid beneficiary when the services or financial support were provided. Services may have been provided in combination with services provided by governmental or other private entities.

To meet condition (b), the services or financial support must fall into one or both of the following two categories:

i. Medical or remedial care or support services that were:

- medically necessary;
- provided directly by the heir or the heir's spouse without compensation, or purchased with the heir's funds; and
- provided while the deceased person required medical care and services consistent with the level of care standard for level III residential care homes at a frequency averaging no fewer than three times per week or, if provided less frequently, constituting the equivalent expenditure of time or money.

The department shall not verify the level of care unless it has a reasonable basis for questioning that the level III standard was met.

ii. Other services or financial support at least as significant as the care or services described in category (i).

When there are two or more heirs, the full value of the homestead is exempt from Medicaid estate adjustment or recovery only if each heir meets conditions (1), (2), and (3) above. When one or more heirs do not meet conditions (1), (2), and (3), the percentage of the value of the homestead corresponding to their share is subject to Medicaid estate adjustment or recovery.

7108.3.3 Adjusting Claims Against Homesteads

An estate includes all real and personal property and other assets listed on an inventory filed in the probate court. The probate court oversees the distribution of assets to heirs and the payment of the decedent's outstanding debts, which requires creditors to submit proof of their claims to the court.

The probate court judge compares the total value of claims filed by creditors to the total value of available assets in the estate. The court determines which assets are available to pay debts.

When any heir meets the department's undue hardship criteria as specified in rule 7108.3, some or all of these available assets may be exempt from adjustment or recovery by the department under these rules. Nonexempt assets are those subject to the department's claim because an heir has not met the undue hardship criteria. Creditors other than the department are not subject to these exemptions.

When the total available assets are insufficient to pay all claims, the probate court prioritizes the debts and prorates each claim according to law. Each creditor collects the resulting percentage of its claim.

If there are sufficient nonexempt assets to allow the department to collect its full percentage, it does so. If the nonexempt assets allow the department to collect only a partial amount of its share after the court's proration, it collects that amount. The department shall maintain its original claim so it can be prorated along with all other creditors claims according to law. The department notifies the court of its decision on the homestead exemption. If the department grants a homestead exemption, it shall inform the court of the maximum payment it will accept against its claim. The department determines the maximum payment it will accept by subtracting the amount of the exemption from the amount of the department's claim.

7108.3.4 Retroactive Homestead Exemptions

The undue hardship exemption applicable to homesteads shall be effective for any probate estate opened after June 30, 1999. Heirs seeking the exemption from July 1, 1999, through the effective date of this policy must submit their claim to the department's Coordination of Benefits unit in the Office of Vermont Health Access within 60 days following receipt of proper notice from the department. In the sole discretion of the commissioner, the department may make exceptions to the 60-day rule when an heir establishes undue hardship due to lack of notice, a medical need, or natural disaster. Heirs seeking an exemption from the 60-day submission requirement must sign an affidavit describing the condition that prevented them from complying with the 60-day submission requirement and submit the affidavit along with supporting documentation to the commissioner.

7108.3.5 Long-Term Care Insurance Partnership Exemption

The department will exempt assets or resources pursuant to rule 4242.2 in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified State long-term care insurance partnership policy whether or not an heir requests an exemption.

7109 Health Care Trust Fund (10/01/1995, 95-28)

In accordance with 33 VSA §1956, a Health Care Trust Fund is established in which proceeds from health care provider taxes shall be deposited. The proceeds of other taxes designated by law and donations may also be deposited in the fund.

Health care provider taxes shall be assessed upon hospitals, nursing homes and intermediate care facilities for the mentally retarded (ICF/MRs) licensed in Vermont, pursuant to 33 VSA §1953, §1954, and §1955, in an amount established by statute.

For each fiscal year in which health care provider taxes are due, the Office of Vermont Health Access (OVHA) shall notify each provider of the amount of its assessment. The notification shall include the appeals provisions set forth in 33 VSA §1958 and shall establish an assessment payment schedule for each provider.

Payment in full of each installment must be sent to the OVHA post marked no later than the date specified for each payment by the Director in the assessment notification. Late payments will be subject to a late fee assessment of eight percent or $1,000, whichever is less. The filing of a request for reconsideration, pursuant to 33 VSA §1958, does not relieve a provider from its obligation to make timely payments.

For hospital fiscal years ending after June 30, 1993, hospitals are required to identify gross inpatient revenues as a separate footnote in their audited financial statements.

7110 Global Commitment Appeals and Grievances (08/01/2010, 10-01)

"Global Commitment" is an 1115(a) Demonstration waiver program under which the Federal government waives certain Medicaid coverage and eligibility requirements found in Title 19 of the Social Security Act. The Department of Vermont Health Access (DVHA) is required under the Global Commitment to Health 1115(a) waiver, to implement all 42 CFR Part 438 regulations, related to Managed Care Organizations, in its operations. Under 42 C.F.R. Part 438, Subpart F, the Managed Care Entity is required to have an internal grievance and appeal process for resolving service disagreements between beneficiaries and the managed care entity, including employees, representatives, and state designated agencies, including Designated Agencies and Specialized Service Agencies.

The Managed Care Entity and any part of the entity receiving funds for the provision of services under Global Commitment shall be responsible for resolving all grievances and all appeals initiated under these rules.

Beneficiaries and providers shall not be subject to retribution or retaliation for filing a grievance or an appeal with the managed care entity.

Services funded with Managed Care Entity investments dollars are not Medicaid covered services, and are therefore not subject to grievance and appeal rules, except as otherwise provided for in rule (see annual DVHA Budget Document - http://DVHA.vermont.gov/budget-legislative). Beneficiaries retain their ability to file fair hearings with the Human Services Board for denials, limitations, reductions, suspensions or terminations of these services.

Note: Unless otherwise stated, all timeframes are stated in calendar days.

7110.1 Definitions (08/01/2010, 10-01)

The following definitions shall apply for use in rules 7110–7110.5:

A. "Action" means an occurrence of one or more of the following by the managed care entity for which an internal appeal may be requested:

1. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;

2. reduction, suspension or termination of a previously authorized covered service or an approved (by the managed care entity) service plan;

3. denial, in whole or in part, of payment for a covered service;

4. failure to provide a clinically indicated, covered service, when the DA/SSA is acting as the managed care entity;

5. failure to act in a timely manner when required by state rule;

6. denial of a beneficiary's request to obtain covered services outside the network.

NOTE: A provider outside the network (i.e. not enrolled in Medicaid) cannot be reimbursed by Medicaid.

NOTE: Collaborative decisions of any type made by multi-disciplinary groups that include managed care entity and non-entity members, such as Local Interagency Teams (LIT), the State Interagency Team (SIT), the State or Local Team for Functionally Impaired, and the Case Review Committee (CRC), are not actions of the managed care entity, see Medicaid Rule 7110.1(H), and therefore are not governed by Medicaid Rule 7110 et seq.

B. "Appeal" means a request for an internal review of an action by the MCO.

C. ""Designated Agency/Specialized Service Agency" (DA/SSA) means an agency designated by the Department of Mental Health (DMH) or Department of Disabilities, Aging and Independent Living (DAIL) to provide services and/or service authorizations for eligible individuals with mental health or developmental disabilities.

D. "Designated Representative" means an individual, either appointed by a beneficiary or authorized under State or other applicable law, to act on behalf of the beneficiary in obtaining a determination or in dealing with any of the levels of the appeal or grievance process. Unless otherwise stated in this rule, the designated representative has all of the rights and responsibilities of a beneficiary in obtaining a determination or in dealing with any of the levels of the appeals process.

E. "Expedited Appeal" means an appeal in an emergent situation in which taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.

F. "Fair Hearing" means an external appeal that is filed with the Human Services Board, and whose procedures are specified in rules separate from the managed care entity grievance and appeal process.

G. "Grievance" means an expression of dissatisfaction about any matter that is not an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the beneficiary's rights.

If a grievance is not acted upon within the timeframes specified in rule, the beneficiary may ask for an appeal under the definition above of an action as being "failure to act in a timely manner when required by state rule."

If a grievance is composed of a clear report of alleged physical harm or potential harm, the managed care entity will immediately investigate or refer to the appropriate investigatory body (fraud, malpractice, professional regulation board, Adult Protective Services).

H. "Managed Care Entity" means and includes:

1. the Department of Vermont Health Access (DVHA);

2. any State department with which DVHA has an Intergovernmental Agreement under Global Commitment, excluding the Department of Education, that results in that department administering or providing services under Global Commitment (i.e. Department for Children and Families; Department of Disabilities, Aging, and Independent Living; Department of Health; Department of Mental Health);

3. a DA/SSA; and

4. any contractor performing service authorizations or prior authorizations on behalf of the managed care entity.

I. "Network" means the providers who are enrolled in the Vermont Medicaid program and who provide services on an ongoing basis to beneficiaries.

J. "Provider" means a person, facility, institution, partnership or corporation licensed, certified or authorized by law to provide health care service to an individual during that individuals medical care, treatment or confinement. A provider cannot be reimbursed by Medicaid unless he/she is enrolled with Medicaid; however, a provider may enroll to serve only a specific beneficiary. A developmental home provider, employee of a provider, or an individual or family that self-manages services is not a provider for purposes of this rule.

K. "Service" means a benefit 1) covered under the 1115(a) Global Commitment to Health waiver as set out in the Special Terms and Conditions approved by the Center for Medicare and Medicaid Services (CMS), 2) included in the State Medicaid Plan if required by CMS, 3) authorized by state rule or law, or 4) identified in the Intergovernmental Agreement between the Department of Vermont Health Access and Agency of Human Services Departments for the administration and operation of the Global Commitment to Health waiver.

7110.2 Beneficiary Appeals (08/01/2010, 10-01)

A. Right to Appeal

Beneficiaries may request an internal appeal of a managed care entity's action, and a fair hearing before the Human Services Board. A beneficiary may utilize the internal appeal process while a fair hearing is pending or before a fair hearing is requested (rule 7110.3), except when a benefit is denied, reduced, or eliminated as mandated by federal or state law or rule, in which case the beneficiary cannot use the appeal process and would challenge the decision only by requesting a fair hearing.

B. Request for Non-Covered Services

An appeal under this rule may only be filed regarding the denial of a service that is covered under Medicaid. Any request for a non-covered service must be directed to DVHA under the provisions of the Medicaid rules at 7104. A subsequent DVHA denial under rule 7104 to cover such service cannot be appealed using the appeal process set forth in this rule, but may be appealed through the fair hearing process.

C. Medicaid Eligibility and Premium Determinations

If a beneficiary files an appeal regarding eligibility for Medicaid or premium determination, the entity that receives the appeal will forward it to the Department for Children and Families (DCF), Economic Services Division. They will then notify the beneficiary in writing that the issue has been forwarded to and will be resolved by DCF. These appeals will not be addressed through the appeal process and will be considered a request for fair hearing as of the date the managed care entity received it.

D. Filing of Appeals

Beneficiaries may file appeals orally or in writing for any managed care action. Providers and representatives of the beneficiary may initiate appeals only after a clear determination that the third-party involvement is being initiated at the beneficiary's request. Appeals of actions must be filed with the managed care entity within 90 days of the date of the notice of action. The date of the appeal, if mailed, is the postmark date.

The appeal process will include assistance by staff members of the managed care entity, as needed, for the beneficiary to initiate and participate in the appeal.

E. Written Acknowledgement

Written acknowledgement of the appeal shall be mailed within 5 days of receipt by the part of the managed care entity that receives the appeal.

If a beneficiary files an appeal with the wrong entity, that entity will notify the beneficiary in writing in order to acknowledge the appeal. This written acknowledgement shall explain that the issue has been forwarded to the correct part of the managed care entity, identify the part to which it has been forwarded, and explain that the appeal will be addressed by that part. This does not extend the deadline by which appeals must be determined.

F. Withdrawal of Appeals

Beneficiaries or designated representatives may withdraw appeals orally or in writing at any time. If an appeal is withdrawn orally, the withdrawal will be acknowledged by the managed care entity in writing within 5 days.

G. Beneficiary Participation in Appeals

The beneficiary, their designated representative, or the beneficiary's treating provider, if requested by the beneficiary, has the right to participate in person, by phone or in writing in the meeting in which the managed care entity is considering the final decision regarding their appeal. If the appeal involves a DA/SSA decision, a representative of the DA/SSA may also participate in the meeting. Beneficiaries, their designated representative, or treating provider may submit additional information that supplements or clarifies information that was previously submitted and is likely to materially affect the decision. They will also be provided the opportunity to examine the case file, including medical records and other documents or records, prior to the meeting.

Upon request, the managed care entity shall provide the beneficiary or their designated representative with all the information in its possession or control relevant to the appeal process and the subject of the appeal, including applicable policies or procedures and (to the extent applicable) copies of all necessary and relevant medical records. The entity will not charge the beneficiary for copies of any records or other documents necessary to resolve the appeal.

H. Appeals Reviewer

The individual who hears the appeal shall not have made the decision subject to appeal and shall not be a subordinate of the individual that made the original decision. Appeals shall be decided by individual(s) designated by the entity responsible for the services that are the subject of the appeal who, when deciding an appeal of a denial that is based on medical necessity or an appeal that involves clinical issues, possess(es) the requisite clinical expertise, as determined by the managed care entity, in treating the beneficiary's condition or disease.

I. Resolution

Appeals shall be decided and written notice sent to the beneficiary within 45 days of receipt of the appeal. The beneficiary shall be notified as soon as the appeal meeting is scheduled. Meetings will be held during normal business hours and, if necessary, the meeting will be rescheduled to accommodate individuals wishing to participate. If a meeting cannot be scheduled so that the decision can be made within the 45-day time limit, the time frame may be extended up to an additional 14 days, by request of the beneficiary or by the managed care entity if the extension is in the best interest of the beneficiary. If the extension is at the request of the managed care entity, it must give the beneficiary written notice of the reason for the delay. The maximum total time period for the resolution of an appeal, including any extension requested either by the beneficiary or the managed care entity, is 59 days. If a meeting cannot

be scheduled within these timeframes, a decision will be rendered by the managed care entity without a meeting with the beneficiary, their designated representative, or treating provider.

7110.2.1 Expedited Appeal Requests

Expedited appeals may be requested in emergent situations in which the beneficiary or the treating provider (in making the request on the beneficiary's behalf or supporting the beneficiary's request) indicates that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. Requests for expedited appeals may be made orally or in writing with the managed care entity for any actions subject to appeal. The managed care entity will not take any punitive action against a provider who requests an expedited resolution or supports a beneficiary's appeal.

If the request for an expedited appeal is denied because it does not meet the criteria, the managed care entity will inform the beneficiary that the request does not meet the criteria for expedited resolution and that the appeal will be processed within the standard 45-day time frame. An oral notice of the denial of the request for an expedited appeal must be promptly communicated (within 2 days) to the beneficiary and followed up within 2 days of the oral notification with a written notice.

If the expedited appeal request meets the criteria for such appeals, it must be resolved within 3 working days. If an expedited appeal cannot be resolved within 3 working days, the time frame may be extended up to an additional 14 days by request of the beneficiary, or by the managed care entity if the extension is in the best interest of the beneficiary. If the extension is at the request of the managed care entity, it must give the beneficiary written notice of the reason for the delay. An oral notice of the expedited appeal decision must be promptly communicated (within 2 days) to the beneficiary and followed up within 2 days of the oral notification with a written notice. The written notice for any expedited appeal determination shall include a brief summary of the appeal, the resolution, the basis for the resolution, and the beneficiary’s right to request a fair hearing if not already requested.

7110.2.2 Participating Provider Decisions

Provider decisions shall not be considered managed care entity actions and are not subject to appeal using this process.

A state agency shall be considered a provider if it provides a service that is:

A. Claimed at the Medicaid service matching rate;

B. Based on medical or clinical necessity; and

C. Not prior authorized.

Designated Agencies/Specialized Service Agencies (DA/SSA) are providers when their decisions do not affect beneficiary eligibility or services.

7110.2.3 Notices, Continued Services, and Beneficiary Liability

A. Beneficiary Notice

The part of the managed care entity issuing a services decision that meets the definition of an action must provide the beneficiary with written notice of its decision. In cases involving a termination or reduction of service(s), such notice of decision must be mailed at least 11 days before the change will take effect. Where the decision is adverse to the beneficiary, the notice must inform the beneficiary:

1. what action is being taken;
2. the reason for the action
3. the specific rule that supports the action; and
4. explain when and how to file an appeal or fair hearing, and that he or she may request that covered services be continued without change as well as the circumstances under which the beneficiary may be required to pay the costs of those services pending the outcome of any appeal or fair hearing.

B. Continuation of Services

1. If requested by the beneficiary, services must be continued during an appeal regarding a Medicaid-covered service termination, suspension, or reduction under the following circumstances:

   a. The managed care entity appeal was filed in a timely manner, meaning before the effective date of the proposed action;

   b. The beneficiary has paid any required premiums in full;

   c. The appeal involves the termination, suspension or reduction of a previously authorized course of treatment or service plan; and

   d. The services were ordered by an authorized provider and the original period covered by the authorization has not expired.

2. Where properly requested, a service must be continued until any one of the following occurs:

   a. The beneficiary withdraws the appeal;

   b. Any limits on the cost, scope or level of service, as stated in law or rule, have been reached;

   c. The managed care entity issues an appeal decision adverse to the beneficiary, and the beneficiary does not request a fair hearing within the applicable time frame;

   d. A fair hearing is conducted and the Human Services Board issues a decision adverse to the beneficiary; or

   e. The time period or service limits of a previously authorized service has been met.

Beneficiaries may waive their right to receive continued benefits pending appeal.

C. Change in Law

Continuation of benefits without change does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law or rule affecting some or all beneficiaries, or when the decision does not require the minimum advance notice (see Notice of Decision at rule 4150).

D. Beneficiary Liability for Cost of Services

A beneficiary may be liable for the cost of any services provided after the effective date of the reduction or termination of service or the date of the timely appeal, whichever is later.

The managed care entity may recover from the beneficiary the value of any continued benefits paid during the appeal period when the beneficiary withdraws the appeal before the relevant managed care entity or fair hearing decision is made, or following a final disposition of the matter in favor of the managed care entity. Beneficiary liability will occur only if an appeal, fair hearing decision, Secretary's reversal and/or judicial opinion upholds the adverse determination, and the managed care entity also determines that the beneficiary should be held liable for service costs.

If the provider notifies the beneficiary that a service may not be covered by Medicaid, the beneficiary can agree to assume financial responsibility for the service. If the provider fails to inform the beneficiary that a service may not be covered by Medicaid, the beneficiary is not liable for payment. Benefits will be paid retroactively for beneficiaries who assume financial responsibility for a service and who are successful on such service coverage appeal.

E. Appeals Regarding Proposed Services

If an appeal is filed regarding a denial of service eligibility, the managed care entity is not required to initiate service delivery.

The managed care entity is not required to provide a new service or any service that is not a Medicaid-covered service while a fair hearing determination is pending.

7110.3 Fair Hearing (08/01/2010, 10-01)

A beneficiary may utilize the managed care entity appeal process and be entitled to a fair hearing before the Human Services Board. Fair hearings or managed care entity appeals must be filed within 90 days of the date the notice of action was mailed by the managed care entity. A request for a fair hearing challenging a managed care entity appeal decision must be made within 90 days of the date the original notice of the managed care entity's decision being appealed was made, or within 30 days of the date the notice of the decision being appealed was mailed, whichever comes later. If the beneficiary's original request for an appeal was filed before the effective date of the adverse action and the beneficiary has paid in full any required premiums, the beneficiary's services will continue consistent with 7110.2.3 B.

Individuals have the right to file requests for fair hearings related to eligibility for Medicaid and premium determinations. DCF shall retain responsibility for representing the State in any fair hearings pertaining to such eligibility and premium determinations.

7110.4 School-Based Health Services (08/01/2010, 10-01)

The State uses the School-Based Health Services Program to obtain Medicaid reimbursement for medical services provided by schools to eligible students. To be eligible, the students must be enrolled in Medicaid, receiving special education services, and receiving Medicaid-billable services. School districts can claim reimbursement under the Program only for those students on an individualized education program ("IEP") and not for students on 504 plans. A release of protected health information for each eligible student is required before any claims can be processed. The parent or guardian has the right to refuse to give consent to such a release. In such case, the school district cannot claim Medicaid reimbursement for any services provided to that student. Additionally, a physician or a nurse practitioner must sign a physician authorization form, establishing that the IEP services are medically necessary.

The federal Individuals with Disabilities Education and Improvement Act of 2004 (IDEIA) Part B has statutes and regulations that govern the process for assessing needs and developing the IEP. Separate Department of Education (DOE) due process and appeals procedures apply when there is a disagreement concerning the services included in the IEP. Parents of a child receiving special education services who disagree with decisions made by the school regarding a child's identification, eligibility, evaluation, IEP or placement have three options available under the DOE procedures for resolving disputes with the school: mediation, a due process hearing and/or an administrative complaint. The Department of Education due process and appeals procedures also apply to Global Commitment services authorized under Part B of IDEIA.

IDEIA Part C is an Early Intervention program for infants and toddlers that provides a broad array of services to children with special needs, birth through three years of age, and their families. Services are authorized through the DCF - Child Development Division. Global Commitment services authorized under Part C of IDEIA are subject to the managed care grievance and appeal procedures.

7110.5 Beneficiary Grievances (08/01/2010, 10-01)

A. Filing Grievances

A grievance may be expressed orally or in writing. A beneficiary or his or her designated representative must file any grievance within 60 days of the pertinent issue in order for the grievance to be considered. Staff members will assist a beneficiary if the beneficiary or his or her representative requests such assistance.

B. Written Acknowledgement

Written acknowledgement of the grievance must be mailed within 5 days of receipt by the managed care entity. The acknowledgement must be made by the part of the managed care entity responsible for the service area that is the subject of the grievance. If the entity decides the issue within the five day time frame, it need not send separate notices of acknowledgement and decision. The decision notice is sufficient in such cases.

C. Withdrawal of Grievances

Beneficiaries or their designated representatives may withdraw grievances orally or in writing at any time. If a grievance is withdrawn orally, the withdrawal will be acknowledged by the managed care entity in writing within five calendar days.

D. Disposition

All grievances shall be addressed within 90 days of receipt. The decision maker must provide the beneficiary with written notice of the disposition. The written notice shall include a brief summary of the grievance, information considered in making the decision, and the disposition. If the response is adverse to the beneficiary, the notice must also inform the beneficiary of his or her right to initiate a grievance review with the managed care entity as well as information on how to initiate such review.

E. Grievance Reviews

1. Filing a Grievance Review - If a grievance is decided in a manner adverse to the beneficiary, the beneficiary may request a review by the managed care entity within 10days of the decision. The review will be conducted by an individual who was not involved in deciding the grievance under review and is not a subordinate of the individual who decided the original grievance.

2. Written Acknowledgement - The managed care entity will acknowledge grievance review requests within 5 days of receipt.

3. Disposition - The grievance review will assess the merits of the grievance issue(s), the process employed in reviewing the issue(s), and the information considered in making a final determination. The primary purpose of the review shall be to ensure that the grievance process has functioned in an impartial manner and that the response was consistent with the issues and/or facts presented. The beneficiary will be notified in writing of the findings of the grievance review within 90 days.

   Although the disposition of a grievance is not subject to a fair hearing before the Human Services Board, the beneficiary may request a fair hearing for an issue raised that is appropriate for review by the Board, as provided by 3 V.S.A. §3091 (a).

7201 Inpatient Services — Medical and Psychiatric (07/26/2012, 12-01)

Coverage for inpatient services is limited to hospitals included in the Green Mountain Care Network. These hospitals are:

A Vermont hospital approved for participation in Medicare; or

Out-of-state hospitals that are included in the Green Mountain Care Network due to their close proximity to Vermont and that it is the general practice of residents of Vermont to secure care and services at these hospitals.

Coverage for hospitals outside of the Green Mountain Care Network is only available if an out-of-network hospital is approved either for Medicare participation or for Medical Assistance (Title XIX) participation by the single state agency administering the Title XIX program within the state where it is located and the admission receives prior authorization. For emergent and urgent inpatient care, notification to DVHA is required within 24 hours of admission or the next business day. For all other inpatient care, an authorization must be obtained prior to the provision of services. Emergent and urgent care is defined in Medicaid Rule 7101.3.

The current list of hospitals included in the Green Mountain Care Network is located on the DVHA web site (http://dvha.vermont.gov/for-providers/green-mountain-care-network).

Coverage for inpatient hospital services is limited to those instances in which the admission and continued stay of the beneficiary are determined medically necessary by the appropriate utilization review authority.

Coverage may also be extended for inpatients who are determined no longer in need of hospital care but have been certified for care in a Nursing Facility. (Medicaid Rule 7606).

7201.1 Inpatient Services (07/26/2012, 12-01)

Covered services include:

A. Care in a semi-private (2-4 beds) room;

B. Private room if certified medically necessary by a physician to avoid jeopardizing the health of the patient or to protect the health and safety of other patients. (No payment will be made for any portion of the room charge when the recipient requests and is provided with a private room for his or her personal comfort; i.e., when the private room is not medically necessary;

C. Use of intensive care unit;

D. Nursing and related services (except private duty nurses);

E. Use of hospital facilities, such as operating and recovery room, X-ray, laboratory, etc;

F. Use of supplies, appliances and equipment, such as splints, casts, wheelchairs, crutches, etc.;

G. Blood transfusions;

H. Therapeutic services, such as X-ray or radium treatment;

I. Drugs furnished by the hospital as part of inpatient care and treatment, including drugs furnished in limited supply to permit or facilitate discharge from a hospital to meet the patient's requirements until a continuing supply can be obtained;

J. Rehabilitation services, such as physical therapy, occupational therapy, and speech therapy services;

K. Diagnostic services, such as blood tests, electrocardiograms, etc., but only when these services are specifically ordered by the patient's physician and they are reasonable and necessary for the diagnosis or treatment of the patient's illness or injury.

7201.2 Excluded Services (07/26/2012, 12-01)

The following inpatient services are excluded:

Private room at patient's request for his personal comfort;

Personal comfort items such as telephone, radio or television in hospital room;

Private duty nurses; and

Experimental treatment and other non-covered procedures.

7201.3 Dental Procedures (07/26/2012, 12-01)

Coverage of inpatient hospital services for dental procedures is only in the following situations:

For beneficiaries age 21 and over:

When a covered surgical procedure is performed (see rule 7312); or

When prior authorization has been granted by the Department of Vermont Health Access in a case where hospitalization was required to assure proper medical management or control of non-dental impairment during performance of a non-covered dental procedure (e.g., a beneficiary with a history of repeated heart attacks must have all their other teeth extracted) and need for such hospitalization is certified by the physician responsible for the treatment of the non-dental impairment. Should the beneficiary already be hospitalized for the treatment of a medical condition and a non-covered dental procedure is performed during the hospital stay, prior authorization is not required. In these instances hospital and anesthesia charges are covered, but the services of the dentist performing the dental services are not.

For beneficiaries under the age of 21:

When prior authorization has been granted by the Department of Vermont Health Access and the DVHA dental consultant certified that the beneficiary required hospitalization either for management of other medical conditions or to undergo dental treatment.

7201.4 Psychiatric Care (07/26/2012, 12-01)

Inpatient psychiatric services provided in a hospital are covered to the same extent as inpatient services related to any other type of care or treatment. Authorization requirements are defined in Rule 7201.

7201.5 Care of Newborn Child (07/26/2012, 12-01)

For the period after the initial seven days or until the mother is discharged, whichever is earlier, coverage for continuing inpatient care of a newborn child requires application for and determination of the newborn child's eligibility, a separate Medicaid identification number and separate billing.

7201.6 Reimbursement (07/26/2012, 12-01)

Reimbursement for inpatient services is described in the Provider Manual, the State Plan, and the UB-04 Billing Manual.

7203 Outpatient Services (02/26/2011, 10-13)

"Outpatient hospital services" are defined as those covered items and services indicated below when furnished in an institution meeting the hospital services provider criteria (rule 7201), by or under the direction of a physician, to an eligible beneficiary who is not expected to occupy a bed overnight in the institution furnishing the service.

Covered items and services include:

- Use of facilities in connection with accidental injury or minor surgery. Treatment of accidental injury must be provided within 72 hours of the accident.
- Diagnostic tests given to determine the nature and severity of an illness; e.g., x-rays, pulmonary function tests, electrocardiograms, blood tests, urinalysis and kidney function tests. Laboratory and radiologic services may be subject to limitations and/or prior authorizations as specified in Rule 7405.
- Diabetic counseling or education services; one diabetic education course per beneficiary per lifetime provided by a hospital-sponsored outpatient program, in addition to 12 diabetic counseling sessions per calendar year provided by a certified diabetic educator. Additional counseling sessions with a diabetic educator may be covered with prior authorization. Medicaid also covers one membership in the American Diabetes Association (ADA) per lifetime.
- Rehabilitative therapies (physical, occupational, and speech) as specified in Rules 7317–7317.2
- Inhalation therapy
- Emergency room care. Use of the emergency room at any time is limited to instances of emergency medical conditions, as defined in rule 7101.3 (a)(13).

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7301.1 Date of this Memo 1/01/2014 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

QUESTION: Have there been any changes in Medicaid coverage of smoking cessation counseling?

ANSWER: Yes. Effective January 1, 2014, the DVHA will cover face-to-face counseling for smoking cessation for all Vermont Medicaid beneficiaries. The maximum number of allowed visits per calendar year and qualified providers who can bill for counseling remains unchanged.

7301 Physicians and Other Licensed Practitioners (07/26/2012, 12-01)

Coverage of physician and other licensed practitioner services are limited to:

Vermont physicians and other specified practitioners licensed by the appropriate licensing agency of the State; or

Out-of-State physicians and other licensed practitioners affiliated with the hospitals included in the Green Mountain Care Network.

All other out-of-state physicians and other licensed practitioners are considered out-of-network and non-emergent, non-urgent office visits are covered only if the service receives prior authorization. Emergent and urgent care is defined in Medicaid Rule 7101.3.

For certain services, a recipient co-payment may be required for a portion of the Medicaid rate (see Obligation of Recipients).

7301.1 Physician Services (07/26/2012, 12-01)

Covered physician services are those provided by a Doctor of Medicine (M.D.), Doctor of Osteopathic Medicine(D.O.), or Naturopathic Doctor (N.D.) when medically necessary and performed within the scope of their licenses.

Routine physical exams, diagnostic services, immunizations, and certain injectable drugs are covered.

Medical and surgical services provided in the home, office, hospital or nursing home are covered with limitations described in rule 7301.1.1.

Supplies used in connection with a physician's treatment are included in the service; some examples of these supplies are tongue depressors, dextrosticks, bandages, antiseptics and other consumable items.

Coverage of face-to-face counseling for smoking cessation for pregnant Vermont Medicaid beneficiaries is limited to 16 visits per calendar year. Services can be provided by physicians, nurse practitioners, licensed nurses, nurse midwives, and physician’s assistants. “Qualified” Tobacco Cessation Counselors are also allowed (requires at least eight hours of training in tobacco cessation services from an accredited institute of higher education).

7301.1.1 Physician Visits

Coverage for physician visits is limited in the following manner:

Office visits - up to five visits per month;

Home visits - up to five visits per month;

Nursing facility visits - up to one visit per week;

Hospital visits - up to one visit per day for acute care, limited to the direct services of a physician, a physician’s assistant, or nurse-midwife.

Visits in excess of those listed above may be covered if there is a significant change in the health status of the patient that requires more frequent visits; prior authorization is required for visits in excess of the limits listed above.

Coverage for surgery services includes postoperative care limited to evaluation and management services compliant with Medicare global-day recommendations.

7301.1.2 Nurse Practitioners

Coverage is limited to enrolled nurse practitioners in either independent practice or affiliated with a physician when certified as: 1) a Nurse-Midwife or 2) a Family Nurse Practitioner or 3) a Pediatric Nurse Practitioner and is limited to Medicaid covered services contained in protocols reviewed and accepted by the Vermont State Board of Nursing and the Vermont State Board of Medical Practice.

7301.2 Psychiatric Services (07/26/2012, 12-01)

Psychiatric services are covered as physician's services for treatment of mental, psychoneurotic, or personality disorders, as defined in the American Psychiatric Association's "Diagnostic and Statistical Manual - Mental Disorders."

7301.2.1 Psychologists Practicing Independently

Diagnostic tests performed by a qualified Vermont psychologist practicing independently of an institution, agency, or physician's office are covered. A "qualified" psychologist is one practicing in the state who has been approved for participation in Medicare by the Part B Carrier or who is licensed in accordance with 26 V. S. A. Chapter 55.

Psychological evaluation includes interviewing, testing, scoring, evaluation and a written report. Group therapy is limited to no more than three sessions per week. Reimbursement is limited to one session per day per group and no more than 10 patients in a group.

7301.2.2 Non-Covered Services

Psychotherapy or diagnostic tests provided by a psychologist practicing independently to an inpatient or outpatient of general hospital or mental hospital or in a community mental health clinic are not covered.

7301.3 Reimbursement (07/26/2012, 12-01)

Reimbursement for physicians and other licensed practitioners is described in the Provider Manual.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7302 **Date of this Memo** 01/12/1994 **Page** 1 of 1

This Memo: [ ] is New [X] Replaces one dated 07/24/1986

QUESTION: What are the new rules regarding federally-funded abortions?

ANSWER: Effective 10/1/93, Federal Medicaid funding is available for abortions which are necessary to save the life of the mother or when the pregnancy is the result of an act of rape or incest.

Under the provisions of a Vermont Superior Court Order, the Department will continue to reimburse Medicaid providers for other medically necessary abortion services furnished to Medicaid-eligible recipients.

Abortion

7302 Abortion (12/01/1980, 80-62)

Providers will be reimbursed by Vermont Medicaid for abortions performed only under circumstances for which Federal Financial Participation is available.

7303 Acupuncture (11/01/2001, 00-31F)

Acupuncture and services performed in connection with acupuncture are not covered.

7304 Chiropractic Services (01/15/2010, 09-17)

Services furnished by a licensed chiropractor certified to meet the standards for participation in Medicare are covered.

Coverage is limited to treatment by means of manipulation of the spine and then only if such treatment is to correct a subluxation of the spine.

The existence of the subluxation may be demonstrated by means of:

A. An x-ray taken at a time reasonably proximate to the initiation of the course of treatment, or

B. Adherence to the clinical review criteria developed by the Vermont Chiropractic Association and the Vermont Medicaid Program. A copy of the clinical review record must be kept on file by the chiropractor and be made available upon request.

An x-ray will be considered "reasonably proximate" if:

In the case of a low grade chronic subluxation complex, it is taken no more than 12 months prior to the initiation of the course of treatment. A re-evaluation x-ray must be performed before the beginning of the third year of continuous care; or

In the case of an acute subluxation, it is taken no earlier than three months prior to the initiation of care (This would justify a course of treatment for a maximum of three months.)

Medicaid does not cover an x-ray ordered solely for the purpose of demonstrating a subluxation of the spine. Any charges incurred for the chiropractic x-ray must be borne by the beneficiary, beneficiary's family, friends or such other community resources as may be available.

Chiropractic services for beneficiaries under the age of 12 require prior authorization from the Office of Vermont Health Access (OVHA). Clinical review data pertinent to the need for treatment must be submitted in writing.

Coverage is limited to ten treatments per beneficiary per calendar year. Exceptional or unusual circumstances may justify a request by the chiropractor for additional coverage. Requests must contain full clinical data, x-rays or other documentation as may be required by the Office of Vermont Health Access, to evaluate the medical necessity for continued care.

Payment for chiropractic treatment will be made at the lower of the actual charge or the Medicaid rate on file.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7305 **Date of this Memo** 09/01/2008 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Do the listed organ transplants (cornea, kidney, heart, heart-lung, liver, and bone marrow) still need prior authorization?

ANSWER: No. Providers must follow established best practices.

7305 Covered Organ and Tissue Transplants (11/01/2001, 00-31F)

Organ transplantation services are covered once the procedure is no longer considered experimental or investigational.

Reimbursement will be made for medically necessary health care services provided to an eligible beneficiary or a live donor and for the harvesting, preservation, and transportation of cadaver organs.

Prior Authorization

Authorization prior to the initiation of services must be obtained from the Office of Vermont Health Access (OVHA) or its designated review agent.

This requirement is administered to assure that organ transplant requests are treated consistently; similarly situated beneficiaries are treated alike; any restriction on the facilities or practitioners that may provide service is consistent with the accessibility of high quality care to eligible beneficiaries; and services for which reimbursement will be made are sufficient in amount, duration, and scope to achieve their purpose.

Standards for Coverage

OVHA or its designated review agent must receive from the beneficiary's attending or referring physician and the transplant center physician the following assurances:

A. The Medicaid beneficiary has a condition for which organ transplantation is the appropriate treatment.

B. All other medically feasible forms of medical or surgical treatment have been considered, and the most effective and appropriate medically indicated alternative for the beneficiary is organ transplantation.

C. The Medicaid beneficiary meets all medical criteria for the proposed type of organ transplantation based upon the prevailing standards and current practices. These would include, but are not limited to:

   1. Test lab results within identified limits to assure successful transplantation and recovery.

   2. Diagnostic evaluations of the beneficiary's medical and mental conditions that indicate there will be no significant adverse effect upon the outcome of the transplantation.

   3. Assessment of other relevant factors that might affect the clinical outcome or adherence to an immunosuppressive regimen and rehabilitation program following the transplant.

   4. The beneficiary or the beneficiary's parent or guardian or spouse has been fully informed of the risks and benefits of the proposed transplant including the risks of complications, continuing care requirements, and the expected quality of life after the procedure.

D. The transplant center meets the following criteria:

   1. Fully certified as a transplant center by applicable state and federal agencies.

   2. Is in compliance will all applicable state and federal laws which apply to organ acquisition and transplantation including equal access and non-discrimination.

   3. Has an interdisciplinary team to determine the suitability of candidates for transplantation on an equitable basis.

4. Provides surgeons who have a minimum of one year of training and experience appropriate to the organ being transplanted which includes experience in transplant surgery, post-operative care and management of an immunosuppressive regimen.

5. At the time Medicaid coverage is requested the center must have performed at least ten transplants of the type requested during the previous twelve months and must provide current documentation that it provides high quality care relative to other transplant centers.

6. Provides all medically necessary services required including management of complications of the transplantation and late infection and rejection episodes. Failure of the transplant is considered a complication and re-transplantation is available at the center.

Liability of Other Parties

Medicaid is always the payer of last resort. Medicare and other insurance coverage for which a Medicaid beneficiary is eligible must discharge liability before a claim for payment will be accepted. Coinsurance and deductible amounts will be paid in an amount not to exceed the Medicaid rate for the service.

Any additional charges made to a beneficiary or beneficiary's family after payment by Medicaid is supplementation and is prohibited.

Providers of health care services specifically funded by research or grant monies may not make claim for payment.

Fertility Services

7306 Fertility Services (11/01/2001, 00-31F)

Fertility services and procedures performed in connection with such services are not covered. Non-covered fertility services include, but are not limited to, in vitro, the GIFT procedure, fertility enhancing drugs, sperm banks, cloning, and services related to surrogacy.

7307 Massage Therapy (11/01/2001, 00-31F)

Massage therapy and services performed in connection with massage therapy are not covered.

Podiatry Services

7308 Podiatry Services (12/01/1980, 80-62)

Covered podiatry services performed by a licensed podiatrist or chiropodist within the scope of his license or by any other physician are limited to non-routine foot care; such as, surgical removal of ingrown toenails, treatment of foot lesions resulting from infection or diabetic ulcers, and similar Medicare covered services. This includes services in connection with covered treatment according to policy applicable to all physicians' services.

The following routine foot care services are excluded, regardless of who performs them (podiatrist, physician, surgeon, etc.):

Treatment of flat foot conditions and supportive devices used in such treatment; and

Treatment of subluxations of the foot (structural misalignments of the joints of the feet) not requiring surgical procedures (i.e., treatment by strapping, electrical therapy, manipulations, massage, etc.); and

Curring or removal of corns or calluses, trimming of nails and preventive or hygienic care of the feet.

The fact that an individual is unable, due to physical disability, to perform routine foot care services for himself does not change the character of the services and make them "non-routine".

7309 Sterilizations and Related Procedures (11/01/2001, 00-31F)

Sterilization of either a male or female beneficiary is covered only when the following conditions are met:

The beneficiary has voluntarily given informed consent and has so certified by signing the consent form included in DHEW Publication No. (OS)79-5006l (Female), or (OS)79-50062 (Male), November, l978 and provided by the Office of Vermont Health Access.

The beneficiary is not mentally incompetent.

The beneficiary is at least 2l years old at the time consent is obtained.

At least 31 days but not more than l80 days have passed between the date of informed consent and the date of sterilization except in the case of premature delivery or emergency abdominal surgery. In those cases, at least 72 hours must have passed between the informed consent and the operation.

Operations or procedures performed for the purpose of reversing or attempting to reverse the effects of any sterilization procedure are not covered.

A hysterectomy is not covered if:

It was performed solely for the purpose of rendering an individual incapable of reproducing; or

If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing; or

Any other hysterectomy is covered only if the beneficiary has been informed as to the nature of the operation and its consequences and has given her consent by signing the Hysterectomy Consent Form.

7310 Surgery (11/01/2001, 00-31F)

A. Cosmetic Surgery

Cosmetic surgery and expenses incurred in connection with such surgery are not covered. Cosmetic surgery encompasses any surgical procedure directed at improving appearance (including removal of tattoos), except when required for the prompt repair of accidental injury or the improvement of the functioning of a malformed body member. For example, the exclusion does not apply (and payment would be made) for surgery in connection with treatment of severe burns or repair of the face following an auto accident or for surgery for therapeutic purposes that coincidentally serves some cosmetic purpose. In questionable cases, authorization prior to performing surgery should be requested from OVHA.

B. Experimental Surgery

Experimental surgery and expenses incurred in connection with such surgery are not covered. Experimental surgery encompasses any surgical procedure not proven to be clinically efficacious by literature and experts in the field.

7311 Medical and Surgical Services of a Dentist (02/01/2006, 05-27)

Medical and surgical services of a dentist means those services furnished by a doctor of dental medicine or dental surgery if the services are services that:

- 1) if furnished by a physician, would be considered physician services; and
- 2) under Vermont law, may be furnished by either a physician or a doctor of dental medicine or surgery.

These services are covered as hospital and/or physician services and subject to the applicable limitations found in rules 7201 through 7316.8. This definition was taken from the federal definition found at 42 CFR §440.50.

7311.1 Eligibility for Care (02/01/2006, 05-27)

Coverage for medical and surgical services of a dentist is provided to all Medicaid beneficiaries.

7311.2 Covered Services (02/01/2006, 05-27)

Services that have been pre-approved for coverage are limited to:

- biopsies;
- repair of lacerations;
- excision of a cyst or tumor;
- reconstructive surgery;
- reduction of a fracture;
- repair of temporomandibular joint dysfunction, including surgical treatment;
- problem-focused limited oral evaluation
- problem-focused limited re-evaluation
- incision and drainage of abscess
- emergency treatment of dental pain – minor procedures

With the exception of services authorized for coverage via rule 7104, other services are not covered.

7311.3 Conditions for Coverage (02/01/2006, 05-27)

Tooth repair, replacement or other dental procedures, even if they are a medically necessary part of the surgery, are addressed under the dental benefit and subject to the limitations of rules 7312 or 7313 as applicable.

7311.4 Prior Authorization Requirements (02/01/2006, 05-27)

Prior authorization is required for all covered services listed above, except for emergency surgery.

Medical and Surgical Services of a Dentist

7311.5 Qualified Providers (02/01/2006, 05-27)

Maxillofacial surgery must be provided by a licensed physician or dentist who is enrolled with Vermont Medicaid.

7311.6 Reimbursement (02/01/2006, 05-27)

Reimbursement for maxillofacial surgery is described in the Provider Manual.

7312 Dental Services for Beneficiaries Under Age 21, and Pregnant and Postpartum Women (12/26/2012, 12-07)

Dental services are preventive, diagnostic or corrective procedures involving the oral cavity and teeth. [See 42 CFR §440.100 & §440.120(b)]

7312.1 Eligibility for Care (12/26/2012, 12-07)

Beneficiaries under the age of 21; or

Pregnant women through the duration of their pregnancy and through the end of the calendar month during which the 60th day following the end of pregnancy occurs.

7312.2 Qualified Providers (12/26/2012, 12-07)

Dental services must be provided by, or under the supervision of, a dentist enrolled in the Green Mountain Care Network.

7312.3 Covered Services (12/26/2012, 12-07)

Medically necessary services include but are not limited to the following general categories:

- prevention, evaluation and diagnosis, including radiographs when indicated;
- periodic prophylaxis, including topical fluoride applied in a dentists office; is limited to once every six months, except more frequent treatments can be authorized by the DVHA;
- periodontal therapy;
- treatment of injuries;
- treatment of disease of bone and soft tissue;
- oral surgery for tooth removal and abscess drainage;
- treatment of anomalies;
- endodontics (root canal therapy);
- restoration of decayed teeth;
- replacement of missing teeth, including fixed and removable prosthetics (i.e. crowns, bridges, partial dentures and complete dentures); and
- non-surgical treatment of temporomandibular joint disorders is limited to the fabrication of an occlusal orthotic appliance (TMJ splint).

The Dental Fee Schedule contains a detailed list of covered dental procedures and services and indicates which require prior authorization.

For coverage of orthodontic services see rule 7314.

7312.4 Non-Covered Services (12/26/2012, 12-07)

Non covered services are those not included or referenced under rule 7312.3.

Local anesthesia is considered part of the dental procedure and shall not be billed as a separate procedure.

Pulp capping and bases are considered incidental to a restoration and shall not be billed as separate procedures.

7312.5 Prior Authorization Requirements (12/26/2012, 12-07)

Prior authorization by the DVHA is required for most special dental procedures.

The Dental Fee Schedule contains a detailed list of covered dental procedures and services and indicates which require prior authorization.

7312.6 Reimbursement (12/26/2012, 12-07)

Reimbursement for dental services is described in the Dental Supplement and the Dental Fee Schedule.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

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Reference 7313.5 Date of this Memo 1/01/2014 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

QUESTION: Has the adult dental maximum changed?

ANSWER: Yes. Effective January 1, 2014, due to the recent dental provider rate increase the adult dental maximum benefit is increased to $510.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation [ ] Medicaid Covered Services Procedure Interpretation

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Reference: 7313.5 Date of this Memo: 09/01/2014 Page 1 of 1

This Memo: [X] is New [ ] Replaces one dated

QUESTION: Is it permissible for providers to bill Medicaid recipients for the portion of the cost that exceeds the dental cap for adults?

ANSWER: Yes. Effective January 1, 2014, adult dental services are capped at $510 per calendar year. Due to the capped dollar amount allowed for adult dental services, providers may, after written acknowledgement of financial liability, bill patients for amounts that exceed the annual capped payment amount but not more than the appropriate procedure rate in the Medicaid dental fee schedule.

This requirement applies only to adult dental services that are covered by Vermont Medicaid.

7313 Dental Services for Beneficiaries Age 21 and Older (12/26/2012, 12-07)

Dental services are preventive, diagnostic, or corrective procedures involving the oral cavity and teeth. [See 42 CFR § 440.100]

7313.1 Eligibility for Care (12/26/2012, 12-07)

Beneficiaries age 21, or older. For dental services for pregnant and postpartum women, age 21 and older, see rule 7312.

7313.2 Qualified Providers (12/26/2012, 12-07)

Dental services must be provided by, or under the supervision of, a dentist enrolled in the Green Mountain Care Network.

7313.3 Covered Services (12/26/2012, 12-07)

Medically necessary services include but are not limited to following general categories:

Dental services:

- prevention, evaluation and diagnosis, including radiographs when indicated;
- periodic prophylaxisis limited to once every six months, except more frequent treatments can be authorized by the DVHA; ;
- limited periodontal therapy;
- treatment of injuries;
- oral surgery for tooth removal and abscess drainage;
- endontics (root canal therapy);
- restoration of decayed teeth; and
- non-surgical treatment of temporomandibular joint disorders is limited to the fabrication of an occlusal orthotic appliance (TMJ splint).

The dental fee schedule contains a detailed list of covered dental procedures and services. It also indicates which procedures and services require prior authorization.

7313.4 Non-Covered Services (12/26/2012, 12-07)

Non covered services are those services not included under rule 7313.3 and services that do not meet criteria specified in rules 7313.5, and 7313.6.

Services that are not covered include: cosmetic procedures; and certain elective procedures, including but not limited to: bonding, sealants, periodontal surgery, comprehensive periodontal care, orthodontic treatment, processed or cast crowns and bridges.

Local anesthesia is considered part of the dental procedure and shall not be covered as a separate procedure.

Pulp capping and bases are considered incidental to a restoration and shall not be covered as separate procedures.

7313.5 Conditions for Coverage (12/26/2012, 12-07)

Coverage of dental services for beneficiaries age 21 or older is limited to a maximum dollar amount of $495 per beneficiary per calendar year. Medical and surgical services of a dentist, as described in rule 7311, are not subject to this maximum dollar amount.

7313.6 Prior Authorization Requirements (12/26/2012, 12-07)

Prior authorization by the DVHA is required for most special dental services. The Dental Fee Schedule contains a detailed list of covered dental procedures and services and indicates which require prior authorization.

7313.7 Reimbursement/Copayments (12/26/2012, 12-07)

Beneficiaries are required to pay a $3.00 co-payment to each provider for services rendered on that day. For exclusions see rule 4161 (C.).

Reimbursement for dental services is described in the Dental Supplement and the Dental Fee Schedule.

7314 Orthodontic Treatment (12/26/2012, 12-07)

Medically necessary orthodontic treatment involves the use of one or more prosthetic devices to correct a severe malocclusion. [See 42 CFR §440.120(c)]

7314.1 Eligibility for Care (12/26/2012, 12-07)

Beneficiaries under the age of 21 when such services are medically necessary; or

Pregnant women through the duration of their pregnancy and through the end of the calendar month during which the 60th day following the end of pregnancy occurs when such services are medically necessary.

7314.2 Qualified Providers (12/26/2012, 12-07)

Interceptive or comprehensive orthodontic services must be provided by a licensed dentist or orthodontist enrolled in the Green Mountain Care Network.

7314.3 Covered Services (12/26/2012, 12-07)

Medically necessary services include but are not limited to the following categories:

- Limited Orthodontic Treatment
- Interceptive Orthodontic Treatment
- Comprehensive Orthodontic Treatment
- Treatment to Control Harmful Habits

The Dental Fee Schedule contains a detailed list of covered orthodontic procedures and indicates which require prior authorization.

7314.4 Prior Authorization Requirements (12/26/2012, 12-07)

Prior authorization is required for all orthodontic treatment.

To be considered medically necessary, the beneficiary's condition must have one major or two minor malocclusions according to diagnostic criteria adopted by DVHA or if otherwise necessary under EPSDT found at rule 4100.

7314.5 Reimbursement (12/26/2012, 12-07)

Approved interceptive treatment is reimbursed in one installment when treatment is started.

Orthodontic Treatment

Comprehensive orthodontic services are reimbursed in four installments. The first payment is made when treatment is started. The next three payments are made at the end of subsequent six-month intervals. As long as the beneficiary is eligible on the first day of the six-month period, full payment will be made for that period, except when the beneficiary will lose coverage during the period due to age limits. In the latter case, partial payment will be made for that portion of the period in which the beneficiary was eligible. If a beneficiary is receiving orthodontic services and becomes eligible for Medicaid coverage and the treatment plan is approved by the DVHA, a partial payment will be made based on the portion of the period covered by Medicaid.

Reimbursement for orthodontic services is described in the Dental Supplement and the Dental Fee Schedule.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7315.4 **Date of this Memo** 02/10/2006 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Have there been any changes in Medicaid coverage for hearing aid repairs?

ANSWER: Yes. Hearing aid repairs are limited to one repair/modification per aid per year. Prior authorization is required when a second or subsequent repair/modification is requested within 365 days of a previous repair/modification.

QUESTION: Have there been any changes in Medicaid coverage for digital hearing aids?

ANSWER: Yes. Vermont Medicaid will cover digital hearing aids, and their repair and replacement, for beneficiaries of any age who meet the clinical criteria outlined in rule 7315.5.

7315 Audiology Services/Hearing Aids (11/01/2001, 00-31F)

Audiology services are those services requiring the application of theories, principles and procedures related to hearing and hearing disorders for the purpose of diagnosis, screening, prevention and correction. This definition is consistent with the federal definition found at 42 CFR §440.110(c).

7315.1 Eligibility for Care (11/01/2001, 00-31F)

Coverage of audiology services is provided to beneficiaries of any age.

7315.2 Covered Services (11/01/2001, 00-31F)

Audiology services that have been pre-approved for coverage are limited to:

- Audiologic examinations;
- Hearing screening;
- Hearing assessments;
- Diagnostic tests for hearing loss;
- Analog hearing aids, plus their repair or replacement for beneficiaries of any age;
- Digital hearing aids, plus their repair or replacement for beneficiaries under age 21;
- Prescriptions for hearing aid batteries - six batteries per month;
- Fitting/orientation/checking of hearing aids; and,
- Ear molds.

7315.3 Conditions for Coverage (11/01/2001, 00-31F)

Payment will be made for hearing aids for beneficiaries who have at least one of the following conditions or if otherwise necessary under EPSDT found at rule 4100:

A. Hearing loss in the better ear is greater than 30dB based on an average taken at 500, 1000, and 2000Hz.

B. Unilateral hearing loss is greater than 30dB, based on an average taken at 500, 1000, and 2000Hz.

C. Hearing loss in the better ear is greater than 40dB base on an average taken at 2000, 3000, and 4000Hz, or word recognition is poorer than 72 percent.

7315.4 Prior Authorization Requirements (11/01/2001, 00-31F)

Prior authorization is required for more than one hearing aid repair per year or any repair in excess of $100.

7315.5 Non-Covered Services (11/01/2001, 00-31F)

Unless authorized for coverage via rule 7104, nonmedical items, such as canal aids and maintenance items other than batteries, and fees associated with selection trial periods or loaners are not covered.

Unless authorized for coverage via rule 7104, digital hearing aids are not covered for beneficiaries age 21 or older.

7315.6 Qualified Providers (11/01/2001, 00-31F)

Audiology services must be provided by a physician or an audiologist who has a certificate of clinical competence from the American Speech and Hearing Association or who has the equivalent education and experience to acquire the certificate or who has completed an academic program and is acquiring supervised work experience to qualify for the certificate. The provider must also be enrolled with Vermont Medicaid.

7315.7 Reimbursement (11/01/2001, 00-31F)

Reimbursement for audiology services is described in the Provider Manual.

7316 Eyewear and Vision Care Services (08/01/2012, 12-03)

Eyeglasses and vision care services are those services requiring the application of theories, principles and procedures related to vision and vision disorders for the purpose of diagnosis and treatment, including lenses, frames, other aids to vision, and therapeutic drugs. This definition is consistent with the federal definition of services found at 42 CFR §440.60(a), 440.120(d), and 441.30.

7316.1 Eligibility for Care (08/01/2012, 12-03)

- Vision care services are provided to beneficiaries of any age.
- Coverage of eyewear (eyeglasses, lenses, contact lenses) is limited to beneficiaries under the age of 21.

7316.2 Qualified Providers (08/01/2012, 12-03)

A. Eye and vision care services must be provided by a licensed physician or optometrist. An optician, optometrist, or ophthalmologist can provide eyeglass-dispensing services

B. Eyeglasses (frames and lenses), repairs and replacements are covered under the terms of the DVHA's sole-source contract.

7316.3 Covered Services (08/01/2012, 12-03)

- Refraction and eye exams when provided by an enrolled ophthalmologist or optometrist.
- Routine eye exams with the following limitations:
  - one comprehensive eye exam and one intermediate eye exam within a two year period, or
  - two intermediate eye exams within a two year period.
- diagnostic testing
- Non-eyewear aids to vision (such as closed circuit television) when the beneficiary is legally blind and when providing the aid to vision will foster independence by improving at least one activity of daily living (ADL or IADL).
- Eyewear with the following limitations:
  - For beneficiaries under the age of six (6):
    - one pair of eyeglass frames per year
    - one new lens per eye per year
    - one fitting per year

    For beneficiaries age six (6) and older and under age 21:
    - one pair of eyeglass frames per two years
    - one new lens per eye per two years
    - one fitting per two years

7316.4 Non-Covered Services (08/01/2012, 12-03)

- Eyeglasses (frames and/or lenses) purchased outside of the DVHA's sole-source contract.
- Services and eyewear not included under rule 7316.3.
- Services and eyewear that do not meet criteria specified in rule 7316.
- Eyewear for beneficiaries age 21 years and older.
- Safety Eyeglasses

7316.5 Conditions for Coverage of Eyewear (08/01/2012, 12-03)

Earlier replacement of eyewear is limited to the following circumstances as documented on the order form:

- eyeglasses (frames or lenses) have been lost, or
- eyeglasses (frames or lenses) have been broken beyond repair, or
- beneficiary's vision has changed by at least one-half diopter in a single lens, or
- frame size changed due to significant inter-pupillary distance change.

7316.6 Prior Authorization Requirements (08/01/2012, 12-03)

Prior authorization is required for:

- contact lenses;
- special lenses;
- photo-sensitive lenses;
- other aids to vision;
- routine eye exams in excess of the number allowed
- frames and/or lenses in excess of the number allowed for any reason other than being broken beyond repair or lost. For example, when lenses are scratched to the extent that visual acuity is compromised (per determination of the qualified provider), approval must be obtained prior to early replacement.
- aids to vision (such as closed circuit television) when the beneficiary is legally blind and when providing the aid to vision would foster independence by improving at least one activity of daily living (ADL or IADL).

7316.7 Reimbursement (08/01/2012, 12-03)

The purchase or replacement of eyeglasses shall be through the DVHA's sole source contract. Reimbursement for vision care services is described in the Provider Manual.

7317 Rehabilitative Therapy Services (02/26/2011, 10-13)

Rehabilitative Therapy services include diagnostic evaluations and therapeutic interventions that are designed to improve, develop, correct, prevent the worsening of, or rehabilitate functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Rehabilitative Therapies include Occupational Therapy (OT), Physical Therapy (PT), and Speech Therapy (ST) (also called Speech/Language Therapy or Speech Language Pathology). The definition and meanings of Occupational Therapy, Physical Therapy, and Speech Therapy can be found in the State Practice Acts at 26 V.S.A. §2081a, §3351, and §4451.

Rehabilitative Therapy services must be:

- directly related to an active treatment regimen designed by the physician; and
- of such a level of complexity and sophistication that the judgment, knowledge, and skills of a qualified therapist are required; and
- reasonable and necessary under accepted standards of medical practice to the treatment of the patient's condition.

NOTE

Not all services listed in the State Practice Acts are medical in nature. Medicaid only covers medically necessary rehabilitative therapy services. Medical necessity is defined in Rule 7103.

7317.1 Limitations (05/01/2012, 11-19)

Quantity limits on services are on a per beneficiary basis, regardless of program or coverage source. Changing programs and/or eligibility during a calendar year does not reset the number of available visits.

These service limitations and prior authorization requirements are not applicable when Medicare is the primary payer.

A. Rehabilitative Therapy Services for Beneficiaries Age 21 and Older

Thirty (30) therapy visits per calendar year are covered and include any combination of physical therapy, occupational therapy and speech/language therapy.

Prior authorization beyond 30 therapy visits in a calendar year will only be granted to beneficiaries with the following diagnoses, and only if the beneficiary meets the criteria found in Rule 7317:

- Spinal Cord Injury
- Traumatic Brain Injury
- Stroke
- Amputation
- Severe Burn

B. Rehabilitative Therapy Services for Beneficiaries Under Age 21

Eight (8) therapy visits from the start of care date per diagnosis/condition for each type (physical therapy, occupational therapy, and speech/language therapy) are covered based on a physician's order. Provision of therapy services beyond the initial 8 visits is subject to prior authorization review as specified below (Rule 7317.2).

7317.2 Prior Authorization Requirements: (02/26/2011, 10-13)

Prior authorization is defined in Rules 7102-7102.4.

To receive prior authorization for additional services a physician must submit a written request to the department with pertinent clinical data showing the need for continued treatment, projected goals and estimated length of time.

7317.3 Rehabilitative Therapy Services: Home Health (02/26/2011, 10-13)

Rehabilitative therapy services provided by a home health agency are covered for up to four months based on a physician's order, for beneficiaries of any age. Provision of therapy services beyond the initial four-month period is subject to prior authorization review as specified below.

Prior Authorization Requirements:

In making its prior authorization decision, the DVHA will obtain and take into consideration a qualified therapist's assessment when determining whether the service may be reasonably provided by the patient's support person(s). In addition, when the department has determined that therapy services may be reasonably provided by the patient's support person(s) and the patient otherwise meets the criteria for authorization of therapy services beyond the initial four-month period, professional oversight of the support person's provision of these services is covered, provided such oversight is medically necessary.

Prior authorization for rehabilitative therapy services beyond one year will be granted only:

- if the service may not be reasonable provided by the patient's support person(s), or
- if the patient undergoes another acute care episode or injury, or
- if th epatient experiences increased loss of function, or
- if deterioration of the patient's condition requiring therapy is imminent and predictable.

7401 Home Health Agency Services (04/01/1999, 98-11F)

Home health agencies provide a variety of services including skilled nursing, therapies, aide services and medical social work to beneficiaries in their home. This definition is consistent with the federal definition found at 42 CFR 440.70.

7401.1 Eligibility for Care (04/01/1999, 98-11F)

Coverage for home health agency service is provided to beneficiaries of any age. Coverage for targeted case management services is limited to at-risk children ages one to five.

7401.2 Covered Services (02/26/2011, 10-13)

Home health agency services that have been pre-approved for coverage are limited to:

- skilled nursing care services;
- rehabilitative therapy services (as specified in Rule 7317.3);;
- home health aide services;
- medical supplies, equipment and appliances suitable for use in the home; and
- targeted case management.

7401.3 Conditions for Coverage (02/26/2011, 10-13)

Home health care services are covered when the conditions for Medicare (Part A or Part B) payment are met or when all of the following conditions are met.

A. General Conditions

For Medicaid reimbursement, there is no homebound restriction, nor is a three-day prior hospitalization required. The patients condition may be either an episode of acute illness or injury or a chronic condition requiring home health care under a physician's order.

Payment for home health services will not be made to any agency or organization that is operated primarily for the care and treatment of a mental disease.

B. Requirement for a Written Plan

Items and services are ordered and furnished under a written plan, signed by the attending physician and incorporated into the agency's permanent record for the patient. The plan relates the items and services to the patient's condition as follows:

- The plan includes the diagnosis and description of the patient's functional limitation resulting from illness, injury or condition.
- It specifies the type and frequency of needed service, ie, nursing services, drugs and medications, special diet, permitted activities, therapy services, home health aide services, medical supplies and appliances.
- It provides a long-range forecast of likely changes in the patient's condition.

- It specifies changes in the plan in writing, signed by the attending physician or by a registered professional nurse on the agency staff pursuant to the physician's oral orders.
- The plan is reviewed by the attending physician, in consultation with professional agency personnel every 62 days, or more frequently as the severity of the patient's condition requires, and shows the day of each review and physician's signature.
- The attending physician certifies that the services and items specified in the treatment plan can, as a practical matter, be provided through a home health agency in the patient's place of residence.

C. Location Where Service is Provided

The service or item is furnished in the beneficiary's place of residence. A place of residence includes beneficiary's own dwelling; an apartment; a relative's home; a place where patients or elderly people congregate such as senior citizen or adult day center; a community care home; and a hospital or nursing home but the last two only for the purpose of an initial observation, assessment and evaluation visit.

D. Coverage of Initial Visit

An initial visit by a registered nurse or appropriate therapist to observe and evaluate a beneficiary either in the hospital, nursing home or community for the purpose of determining the need for home health services is covered. If physician-ordered treatment is given during the initial visit, the two services may not be charged separately.

E. Requirements Specific to Nursing Care

Nursing care services are covered when the services are related to the care of patients who are experiencing acute or chronic periods of illness and those services are:

- ordered by and included in the plan of treatment established by the physician for the patient; and
- required on an intermittent basis; and
- reasonable and necessary to the treatment of an illness, injury or condition.

F. Requirements Specific to Home Health Aide Services

Services of a home health aide are covered when assigned in accordance with a written plan of treatment established by a physician and supervised by a registered nurse or appropriate therapist. Under appropriate supervision, the home health aide may provide medical assistance, personal care, assistance in the activities of daily living such as helping the patient to bathe, to care for hair or teeth, to exercise and to retrain the patient in necessary self-help skills. In cases where home health aides are assigned to patients requiring specific therapy, the home health aide must be supervised by the appropriate therapist; however, it is not necessary in these cases to require an additional supervisory visit by the nurse to supervise the provision of personal services. During a particular visit, the home health aide may perform household chores (such as changing the bed, light cleaning, washing utensils, assisting in food preparation) that are incidental to the visit. Supervisory visits by a registered nurse or appropriate therapist must be performed at least every 62 days, and more frequently if necessary.

G. Requirements Specific to Medical Supplies

Medical supplies are covered when they are essential for enabling home health agency personnel to effectively carry out the care and treatment that has been ordered for the patient by the physician and used during the visit. These items include catheters, needles, syringes,

surgical dressings, and materials used for dressings such as cotton gauze and adhesive bandages. Other medical supplies include, but are not limited to, irrigating solution, and intravenous fluids and oxygen. Certain supplies are not covered; see rule 7401.5.

H. Requirements Specific to Durable Medical Equipment

The rental of durable medical equipment (DME) included on the list of DME items pre-approved for coverage (see Rule 7505.2), that the home health agency owns and is used by a patient as part of the plan of care, is covered when the conditions of coverage, where applicable, as described in Rule 7505.3 are met. Coverage of rental of a specific item of DME may be subject to prior authorization (see Rule 7505.4). The DME coverage limitations described in Rule 7505.5 also apply to DME provided by a home health agency.

I. Requirements Specific to Targeted Case Management Services

Targeted case management services are provided only to children ages one to five who are at-risk for unnecessary and avoidable medical interventions and who do not have another primary case management provider whose responsibility is to provide or coordinate the interventions included in this service. The Vermont Department of Health will review and determine how many targeted case management visits shall be authorized to at-risk children ages one to five.

J. Requirements Specific to Therapy Services

Physical, occupational, and speech therapy services are covered for up to four months based on a physicians order. Provision of these services beyond this initial four-month period requires prior authorization. Therapy services must be:

- directly related to an active treatment regimen designed by the physician; and
- of such a level of complexity and sophistication that the judgment, knowledge, and skills of a qualified therapist are required; and
- reasonable and necessary under accepted standards of medical practice to the treatment of the patient's condition.

Therapy services provided outside the home and requiring equipment that cannot be brought to the home are covered provided that the agency has met certifying standards for that service under Medicare.

7401.4 Non-Covered Services (02/26/2011, 10-13)

With the exception of services authorized for coverage via rule 7104, services not included under rule 7401.2 and services that do not meet criteria specified in rules 7401.2–7401.4, where applicable, are not covered.

Routine low-cost medical supplies, such as cotton balls and tongue depressors, are deemed to be included in the home visit charges and will not be paid for separately.

7401.5 Qualified Providers (02/26/2011, 10-13)

Home health agency providers must be a Medicaid-certified provider and be enrolled with Vermont Medicaid.

Home Health Agency Services

7401.6 Reimbursement (02/26/2011, 10-13)

Reimbursement for home health agency services is described in the Provider Manual. If all conditions for Medicare are met and the patient is Medicare eligible, Medicare must be billed before Medicaid reimbursement is requested.

7402 Hospice Services (06/01/1987, 87-8)

Hospice services to terminally ill recipients are covered in accordance with Section 1905(o) of the Social Security Act.

Hospice services must be rendered by a Medicare certified hospice and be provided in accordance with Medicare regulations.

Recipients of hospice care are required to sign an election of hospice care which waives all other Medicaid coverage except the services of a designated family physician, ambulance service and services unrelated to the terminal illness.

Payment to enrolled hospice providers will be made at the daily rates set by Medicare for each provider. The total number of days of hospice coverage is limited to 210 days. Rates of payment and total reimbursement for hospice care will be made in accordance with Medicare reimbursement and audit principles.

Medicaid will make no payment to the hospice selected by the Medicaid recipient for any services or supplies other than the hospice service.

The hospice may not charge any amount to or collect any amount from the recipient or the recipient's family for a covered hospice service during the period of hospice coverage.

7403 Clinic Services (10/02/1984, 84-46)

Covered clinic services include the following:

Covered physicians' services billed by the clinic on the physician's behalf under an agreement with the physician; and

Services and medical supplies furnished by the clinic incident to covered physicians' services.

7403.1 Mental Health Clinics (10/02/1984, 84-46)

For policies, amount, duration and scope of benefits, and reimbursement rates, see the Department of Mental Health regulations #8l-A20. The Department of Mental Health is also responsible for determining provider eligibility as a Community Mental Health Clinic.

7403.2 Indian Health Service Facilities (10/02/1984, 84-46)

Indian Health Service facilities are accepted as providers on the same basis as other qualified providers. The facility need not obtain a license, but must meet all applicable standards for licensure.

7403.3 Rural Health Clinics (12/01/1980, 80-62)

Coverage is limited to rural health clinics which have been certified for participation in Medicare as evidenced by a current agreement signed by the Secretary of HHS.

Reimbursable rural health clinic services are:

Services performed by a physician who is employed by the clinic to provide such services; and

Services and supplies incident to a physician's service if they are of a type commonly furnished in physicians' offices; of a type commonly rendered either without charge or included in the rural health clinic's bill; furnished as an incidental, although integral, part of a physician's service; furnished under the direct, personal supervision of a physician; and, in the case of a service, furnished by a member of the clinic's health care staff. Only drugs and biologicals which cannot be self-administered are included in this benefit (see rule 7501 for pharmaceutical items); and

Nurse practitioner and physician assistant services if they are furnished by a qualified professional employed by the clinic; furnished under the medical supervision of a physician; furnished in accordance with medical orders prepared by a physician; of a type the practitioner is legally permitted to perform in the State; and of a type that would be coverable if furnished by a physician; and

Services and supplies incident to a nurse practitioner's or physician assistant's services if they are of a type commonly furnished in physicians' offices; of a type commonly rendered either without charge or included in the clinic's bill; furnished as an incidental, although integral, part of professional services of a nurse practitioner or physician assistant service; furnished under direct personal supervision of a nurse practitioner or physician assistant; and, in the case of a service, furnished by a member of the clinic's health care staff. Only drugs and biologicals which cannot be self-administered are included in this benefit (see rule 7501 for pharmaceutical items).

Payment for rural health clinic services will be made in accordance with rates established for purposes of reimbursement under Medicare as provided in 42 CFR 405.2425.

7405 Laboratory and Radiology Services (02/26/2011, 10-13)

Services Covered laboratory and radiology services include the following:

- Microbiological, serological, hematological and pathological examinations; and
- Diagnostic and therapeutic imaging services; and
- Electro-encephalograms, electrocardiograms, basal metabolism readings, respiratory and cardiac evaluations.

Coverage is extended to independent laboratories and radiological services approved for Medicare participation for services provided under the direction of a physician and certification that the services are medically necessary.

When the place of service is "hospital inpatient", coverage for the technical component is included in the per diem hospital reimbursement. When the place of service is "hospital outpatient", coverage is included in the hospital reimbursement on the outpatient claim form for the technical component. Reimbursement for the professional component will be made only to a physician.

Anatomic pathology services form an exception to the place of service and component coverage. Total procedure codes may be used for anatomic pathology services performed by a laboratory outside the hospital in which the beneficiary is an inpatient or for an independent laboratory performing tests for registered inpatients.

7405.1 Limitations: (02/26/2011, 10-13)

Laboratory services for urine drug testing is limited to eight (8) tests per calendar month for beneficiaries age 21 and older. This limitation applies to tests provided by professionals, independent labs and hospital labs for outpatients.

7405.2 Prior Authorization — Radiology: (02/26/2011, 10-13)

The following outpatient high-tech imaging services require prior authorization:

- computed tomography (CT) (previously referred to as CAT scan);
- computed tomographic angiography (CTA);
- magnetic resonance imaging (MRI);
- magnetic resonance angiography (MRA);
- positron emission tomography (PET); and
- positron emission tomography-computed tomography (PET/CT).

The following imaging services do not require prior authorization:

- those provided during an inpatient admission;
- those provided as part of an emergency room visit;
- x-rays, including dual x-ray absorptiometry (DXA) images;
- ultrasounds; or

- mammograms.

7405.3 Prior Authorization — Laboratory: (02/26/2011, 10-13)

Exceptions to the limitations in Rule 7504.1 must be prior approved.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7406 Date of this Memo 02/01/2003 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

QUESTION: What is Participant-Directed Attendant Care (PDAC), and where can I find those regulations?

ANSWER: Participant-Directed Attendant Care is a Medicaid-covered service, which provides physical assistance with activities of daily living and instrumental activities of daily living.

Participant directed attendant care is covered when the individual requires physical assistance with a minimum of two activities of daily living due to a chronic physical condition, and has the personal capacity to obtain and direct attendant care services (including serving as an employer to hire, train, schedule, supervise, and fire attendants.)

At least annually, the need for Participant-Directed Attendant Care will be reviewed and authorized by the Department of Aging and Independent Living.

Attendant Services Program Regulations are published by the Department of Aging and Independent Living (DAIL), and are available upon request by calling DAIL at 802 241-2400.

7406 Personal Care Services (10/29/2013, 13P016)

7406.1 Definitions (10/29/2013, 13P016)

As used in these regulations:

A. "Activities of Daily Living" (ADL) includes dressing; bathing; grooming; eating; transferring; mobility; and toileting.

B. "Employer" means the individual or entity who is responsible for the hiring of and ensuring payment to the provider.

C. "Functional Evaluation Tool" means a standardized assessment tool to assist in the determination of medical necessity for personal care services.

D. "Instrumental Activities of Daily Living" (IADL) includes personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management.

E. "Medical Necessity" shall have the same meaning as Section 7103 of this rule.

F. "Personal care services" means medically necessary services related to ADLs and IADLs that are furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for people with developmental disabilities, or institution for mental disease.

G. "Personal Care Attendant" means an individual at least 18 years of age having successfully passed required background checks who provides the personal care services to a child. A personal care attendant may not be a biological or adoptive parent, guardian, shared living provider, foster parent, step-parent, domestic/civil union partner of the child's primary caregiver, or a relative serving in the primary caregiver capacity.

7406.3 Eligibility Criteria (10/29/2013, 13P016)

To be eligible for Personal Care Services a child must:

A. Be under the age of 21;

B. Have active Medicaid enrollment;

C. Have a medical condition, disability or cognitive impairment as documented by a physician, psychologist, psychiatrist, physician's assistant, nurse practitioner or other licensed clinician and;

D. Qualify for medically necessary personal care services based on functional limitations in age-appropriate ability to perform ADLs.

7406.4 Covered Services (10/29/2013, 13P016)

A. Covered personal care services must be medically necessary and shall include:

1. Assistance with ADLs; such as bathing, dressing, grooming, bladder, or bowel requirements;

2. Assistance with eating, or drinking and diet activities;
3. Assistance in monitoring vital signs;
4. Routine skin care;
5. Assistance with positioning, lifting, transferring, ambulation and exercise;
6. Set-up, supervision, cueing, prompting, and guiding, when provided as part of the assistance with ADLs;
7. Assistance with home management IADLs that are linked to ADLs, and are essential to the beneficiary's care at home;
8. Assistance with medication management;
9. Assistance with adaptive or assistive devices when linked to the ADLs;
10. Assistance with the use of durable medical equipment when linked to the ADLs;
11. Accompanying the recipient to clinics, physician office visits, or other trips which are medically necessary.

B. Services shall be individualized and shall be provided exclusively to the authorized individual.

C. Payment for services shall not exceed the amount awarded.

D. Prior authorization shall be required prior to the provision of personal care services.

E. Services must be provided in the most cost effective manner possible.

7406.5 Personal Care Attendants (10/29/2013, 13P016)

A. A personal care attendant may be employed

1. By home health agencies, nursing service agencies, or other agencies designated to furnish this service; or
2. Directly by the recipient, family, guardian, or guardian's designee (known as self/family/surrogate directed services). In the case of self, family, or surrogate direction, the employer must use the state-sanctioned fiscal employer agent for payroll and administrative services.

B. Personal care attendants may be paid within the awarded amount:

1. The current Medicaid rate on file. The current Medicaid rate is published on the website of the Department of Vermont Health Access and may be found at http://dvha.vermont.gov/ and is hereby incorporated by reference; or
2. A flexible wage. The flexible wage shall not be lower than the current Medicaid rate on file, but may be reasonably higher.
3. The recipient, if an adult between the ages of 18 and 21, or his or her guardian, or the parent or guardian of a minor child, may select the personal care attendant's reasonable rate of pay. Different rates of pay may be paid to different personal care attendants providing services to the same child.

C. Personal Care Attendant Wages and Payroll Taxes –The employer is responsible for paying the appropriate payroll taxes out of the awarded amount.

D. A personal care attendant may provide personal care services to only one recipient at a time.

7406.6 Determination of Personal Care Services (10/29/2013, 13P016)

A. The State shall from time to time adopt and designate for use a functional evaluation tool.

B. The functional evaluation tool shall assist in measuring the level of assistance a recipient requires in activities of daily living and such instrumental activities of daily living linked to the recipient's ADLs.

C. Reevaluations will occur in accordance with the following:

1. Annually through age 5;

2. Changing to every 3 years if the child has two consecutive years of the same evaluation outcome; or

3. When there is a change in the child's ability to perform ADLs and IADLs.

Ambulance Services

7407 Ambulance Services (10/02/1984, 84-46)

In order for ambulance services provided to eligible Medicaid recipients to be covered, the following conditions must be met:

The vehicle and personnel must be certified for participation in Medicare; and

Other methods of transportation must be medically contra-indicated. No payment will be made when some means of transportation other than an ambulance could have been used without endangering the individual's health; and

The ambulance service must be ordered by a physician or certified as to necessity by a physician at the receiving facility; and

The patient must be transported to and accepted as an inpatient or as an emergency outpatient in an institution (i.e., a hospital or skilled nursing facility) whose locality (i.e., the service area surrounding the institution from which individuals normally come or are expected to come) encompasses the place where the transportation began and which would be expected to have the appropriate facilities for the treatment of the injury or illness involved. Coverage is also provided for transporting of an inpatient of a hospital or skilled nursing facility to his home.

Prior authorization from the Office of Vermont Health Access is required to qualify for reimbursement for transportation to an out-of-state hospital. An out-of-state hospital is any hospital located outside the borders of Vermont except those listed in rule 7201.

Non-Covered Services

Ambulance services provided to a hospital inpatient for the purpose of transporting the patient to and from another facility for outpatient services not available at the hospital where the patient was admitted are not covered.

7407.1 Reimbursement (12/01/1988, 88-50F)

Payment for ambulance services will be at the lower of:

The actual charge made for the base rate for the trip and each loaded mile; or

the Medicaid reimbursement rate on file.

The provider must accept Medicaid payment as payment in full. Supplementation from any source is prohibited.

7408 Transportation (10/01/1986, 86-16F)

Transportation to and from necessary medical services is covered and available to eligible Medicaid recipients on a statewide basis.

The following limitations on coverage shall apply:

A. Prior authorization is required. (Exceptions may be granted in a case of a medical emergency.)

B. Transportation is not otherwise available to the Medicaid recipient.

C. Transportation is to and from necessary medical services.

D. The medical service is generally available to and used by other members of the community or locality in which the recipient is located. A recipient's freedom of access to health care does not require Medicaid to cover transportation at unusual or exceptional cost in order to meet a recipient's personal choice of provider.

E. Payment is made for the least expensive means of transportation and suitable to the medical needs of the recipient.

F. Reimbursement for the service is limited to enrolled transportation providers.

G. Reimbursement is subject to utilization control and review in accordance with the requirements of Title XIX.

H. Any Medicaid-eligible recipient who believes that his or her request for transportation has been improperly denied may request a fair hearing. For an explanation, see the "Fair Hearing Rules" listing in the Table of Contents.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7409 **Date of this Memo** 02/01/2003 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Rule 7409 states that the negotiated rates for family planning services from Planned Parenthood of Vermont are all-inclusive. Has that changed?

ANSWER: Yes. First, Planned Parenthood of Vermont has joined with Maine and New Hampshire to form Planned Parenthood of Northern New England.

Second, the negotiated rates have been unbundled, so are no longer all-inclusive. Tests, drugs, supplies, and contraceptive devices may be billed separately.

Planned Parenthood of Vermont

7409 Planned Parenthood of Vermont (10/01/1983, 83-14)

Covered family planning services include medically oriented services furnished by Planned Parenthood of Vermont, Incorporated (PPV). "Medically oriented" services are those furnished:

Directly by physicians, registered nurses and licensed practical nurses employed by PPV; and

By auxiliary personnel such as aides, counsellors and technicians but only when there is direct supervision by the physician.

Direct supervision requires that the physician be on the premises during the time services of auxiliary personnel are rendered.

Family planning services furnished by PPV will be reimbursed at the negotiated rates.

These are all-inclusive rates and no additional payment will be made for tests, drugs, supplies or contraceptive devices.

All payments made to PPV will be deemed to qualify as family planning services and subject to the increased Federal financial participation contained in Section l903(a)(5) of the Social Security Act. Similarly family planning services and supplies provided by other participating physicians, pharmacies and hospitals will qualify for the increased Federal match.

7410 Early and Periodic Screening, Diagnosis and Treatment (EPDST) (11/01/1981, 81-74)

Section 403(g) of the Social Security Act and 45 CFR 249.l0 (b)(4)(iii) require the state agency for Medicaid to develop a program of Screening, Diagnosis and Treatment (EPSDT) in three basic areas:

Informing all Reach Up families of the availability of child health screening services; and

Providing or arranging for the provision of such screening services in all cases where they are requested; and

Arranging for further diagnosis and corrective treatment, the need for which is disclosed by screening services.

7410.1 Informing (11/01/1981, 81-74)

Reach Up families are informed of EPSDT services by means of the following:

District Office staff explanation of EPSDT to each family during initial determination and each re-determination of eligibility; and

A mailing piece outlining EPSDT enclosed with all Reach Up checks at least once during each calendar year; and

Informational brochures about EPSDT are displayed at each District Office and distributed throughout the State for use in hospitals, physicians' offices, day care centers, and other appropriate locations; and

Outreach activities to enlist participation of Medicaid eligibles in EPSDT performed by staff employed by the Department of Health under a special agreement with OVHA.

7410.2 Screening and Outreach (11/01/1981, 81-74)

Under the terms of the special agreement, the Department of Health makes available the complete EPSDT screening package through its Well-Child Conferences. In addition, OVHA reimburses physicians, clinics, and other appropriate providers directly through its fiscal agent for screening services they may furnish to EPSDT eligibles.

7410.3 Corrective Treatment (11/01/1981, 81-74)

The family receives information about the health care resources available in the community that furnish further diagnostic and treatment services. Department of Health staff offers assistance, when requested, in securing services from these providers. At suitable intervals, follow-up contacts are made with the family to encourage them to pursue treatment plans to completion.

7410.4 Rates of Payment (11/01/1981, 81-74)

The Department of Health is reimbursed pursuant to the agreement. Other providers furnishing EPSDT services are reimbursed in accordance with the appropriate section of these regulations; e.g., physicians are reimbursed as per rule 7301.

7411 Private Non-Medical Institutions (07/01/1999, 99-12)

A Private Non-Medical Institution (PNMI) is a facility that provides medical care to its residents. The facility is enrolled as a Medicaid provider and receives Medicaid reimbursement for the actual medical services that are provided to Medicaid beneficiaries residing in the facility. This definition of a PNMI is consistent with federal regulations at 42 CFR § 434.2.

7411.1 Residential Child Care Facilities (07/01/1999, 99-12)

These facilities are residential child care facilities that are maintained and operated for the provision of child care services, as defined in 33 VSA § 306, and are licensed by the Department for Children and Families under the "Licensing Regulations for Residential Child Care Facilities".

Services may be provided by physicians, psychologists, R.N.s, L.P.N.s, speech therapists, occupational therapists, physical therapists, licensed substance abuse counselors, Masters degree social workers, and other qualified staff carrying out a plan of care. Such plans of care, or initial assessments of the need for services, must be prescribed by a physician, psychologist, or other licensed practitioner of the healing arts within the scope of his/her practice under State law.

7411.2 Prior Authorization (07/01/1999, 99-12)

All admissions to private non-medical institutions for which Medicaid reimbursement is anticipated must be prior authorized by the placing agency, i.e., the Department for Children and Families, the Department Mental Health, the Department of Disabilities, Aging and Independent Living, or the Department of Education or Local Education Agency.

7411.3 Reimbursement (07/01/1999, 99-12)

Reimbursement for these services is made at per diem rates based on a cost-based prospective rate setting system as described in the Private Non-Medical Institution section of the Medicaid Practices and Procedures Manual. Such rates include the following three components:

A. treatment,

B. room, board, and supervision

C. education.

No Medicaid reimbursement is made for the room and board or educational components of the rates.

7411.4 Assistive Community Care Facilities (07/01/1999, 99-12)

These PMNI facilities must be licensed by the Department of Disabilities, Aging and Independent Living as level III residential care homes and must be in good standing with the licensing agency in order to become a certified Medicaid provider.

The medical services provided in an Assistive Community Care facility include:

Case Management: Case management assists residents in gaining access to needed medical, social, and other services in order to promote the residents independence in the facility. In addition case management includes coordinating referrals required to link the resident and family to services specified in the residents plan of care, and consultation to providers and support person(s).

Assistance with the Performance of Activities of Daily Living: Assistance with the performance of activities of daily living includes help with meals, dressing, movement, bathing, grooming, or other personal needs.

Medication Assistance, Monitoring and Administration: Medication assistance, monitoring and administration include those activities defined and described in the Vermont Residential Care Home Licensing Regulations adopted 10/7/93 at 2.2b, 2.2.a, and 5.9 (see pages 3, and 25 – 31).

24-hour On-site Assistive Therapy: Assistive therapy includes activities, techniques or methods designed to improve cognitive skills or modify behavior. Assistive therapy is furnished in consultation with a licensed professional, such as a registered or practical nurse, physician, psychologist, mental health counselor, clinical social worker, qualified mental retardation professional (QMRP), or special educator.

Restorative Nursing: Restorative nursing includes services that promote and maintain function. Restorative nursing services are specified in the residents service plan and may be provided in a group setting.

Nursing Assessment: Nursing assessment includes completion of an initial and periodic re-assessment of the resident, and other skilled professional nursing activities that include evaluation and monitoring of resident health conditions and care planning interventions to meet a residents needs at the times specified by the Vermont Residential Care Home Licensing Regulations for Level III residential care homes.

Health Monitoring: Health monitoring includes resident observation and appropriate reporting or follow-up action by residential care home staff, in accordance with the Residential Care Home Licensing Regulations adopted 10/7/1993.

Routine Nursing Tasks: Routine nursing tasks are performed by trained personal care or nursing staff with overview from a licensed registered nurse in accordance with the Vermont Residential Care Home Licensing Regulations adopted 10/7/1993 and the Vermont Nurse Practice Act. Assistive Community Care Services reimbursement is not designed to compensate for care which requires a variance under the Vermont Residential Care Home Licensing Regulations adopted 10/7/1993, or which cannot be performed while meeting the needs of the total resident population of a home.

7411.5 Reimbursement (07/01/1999, 99-12)

Reimbursement for assistive community care services is made at a single per diem rate for all residential care homes enrolled in Medicaid to provide this service. This reimbursement does not cover room and board services provided to Medicaid beneficiaries.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7501 **Date of this Memo** 07/15/2009 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Who is affected by the rule as it related to a 90–day supply?

ANSWER: The rule applies to persons using the selected maintenance drug classes when they are eligible under Medicaid, VHAP-Pharmacy, VScript or VScript Expanded when Medicaid, VHAP-Pharmacy, VScript or VScript Expanded is their primary coverage. This means that the rule does not apply to persons who are on Medicare or covered by private insurance. the list of maintenance drugs requiring a 90–day fill is on the OVHA webpage: http://ovha.vermont.gov/for-providers/pharmacy-programs-bulletins-alerts.

QUESTION: What happens when a physician or medical professional licenses to prescribe drugs in Vermont wants to request an exception to the 90–day supply policy?

ANSWER: When a pharmacy submits a claim for payment for a drug in a selected 90 day supply class, the claim will deny unless there is an exception authorization on file. The prescriber should request an exception when he/she believes in his/her clinical and professional judgement there is an extenuating circumstance to justify an exception. A request must be patient and drug specific. To facilitate the request, the prescriber should submit the Exception to Required 90 Day Maintenance Medication Fill form found on the web page of the Office of Vermont Health Access at: http://ovha.vermont.gov/for-providers/pharmacy-prior-authorization-request-forms using the instructions found on the form.

QUESTION: Will the prescriber have to do anything to request a lesser day supply for the initial fill?

ANSWER: The prescriber does not have to do anything to request the initial supply. When the prescriber writes the new script the pharmacy will indicate it is a new script when submitting the claim for payment. That indication will exclude that first script from the requirement.

7501 Pharmaceuticals, Medical Supplies and Equipment — General Information (01/15/2010, 09-17)

Pharmaceutical items include drugs, medicine chest supplies, vitamins and related items which are normally obtained through appropriately licensed pharmacies. Medical supplies and equipment include prosthetic devices, durable and non-durable equipment for care of the ill or injured, medical supplies and similar items which may be obtained from a pharmacy, hospital-surgical supply service or home health agency.

Payment for covered items, other than prescribed drugs, is limited to the following providers:

- A Vermont provider approved for participation in Medicare; or
- An out-of-state provider, approved either for Medicare participation or for Medical Assistance (Title XIX) participation by the single state agency administering the Title XIX Program within the state where it is located.

Payment for prescribed drugs is limited to Vermont Medicaid enrolled providers who are:

- Registered Vermont pharmacies, including hospital pharmacies; or
- Pharmacies appropriately licensed in another state; or
- A physician, serving an area without regular pharmacy services, who has been granted special approval to bill these items direct.

Payment is limited to covered items furnished on written prescription of a duly licensed medical professional licensed by the state of Vermont to prescribe within the scope of his or her practice and enrolled in Vermont Medicaid, or on telephoned prescription from a prescriber as previously described and enrolled in Vermont Medicaid processed in compliance with applicable federal and state statutes and regulations.

"Maintenance drug" means a drug approved by the FDA for continuous use and prescribed to treat a chronic condition for a prolonged period of time of 30 days or longer, and includes insulin, an insulin syringe and an insulin needle.

Apart from the select drugs used for maintenance treatment described below, all other maintenance drugs must be prescribed and dispensed for not less than 30 days and not more than 90 days. Excluded from this requirement are drugs which the beneficiary takes or uses on an “as needed” basis or generally used to treat acute conditions. If there are extenuating circumstances in an individual case which, in the judgment of the prescriber, dictate a shorter prescribing period for these drugs, the supply may be for less than 30 days as long as the prescriber prepares in sufficient written detail a justification for the shorter period. The extenuating circumstance must be related to the health and/or safety of the beneficiary and not for convenience reasons. It is the responsibility of the pharmacy to maintain in the beneficiary’s record the prescriber’s justification of extenuating circumstances.

Select drugs used for maintenance treatment must be prescribed and dispensed in increments of 90-day supplies. The drug utilization review board shall make recommendations to the director on the drugs to be selected. This limit shall not apply when the beneficiary initially fills the prescription in order to provide an opportunity for the beneficiary to try the medication and for the prescriber to determine that it is appropriate for the beneficiary’s medical needs. If there are extenuating circumstances in an individual case which, in the judgment of the prescriber, dictate a shorter prescribing period, an exception form that identifies the individual and the reason for the exception may be filed with the Office of Vermont Health Access.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7501.1 **Date of this Memo** 01/01/2006 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: If an individual is making a good faith effort to utilize the prescription drug plan's appeal process through the Independent Review Entity level, but the time frame has extended beyond 30 days, will the individual be deemed to have exhausted their appeal for purposes of being able to apply to OVHA for coverage of the drug?

ANSWER: Yes. The appeal process should continue while OVHA's decision is being made and while any coverage exists.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7501.1 **Date of this Memo** 03/01/2006 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

CLARIFICATION:

The requirement to be enrolled in a drug plan (PDP or MA-PD) is met only when the individual has enrolled in a PDP or a MA-PD that is licensed to do business in the State of Vermont.

Up to five refills are permitted if allowed by federal or state pharmacy law.

For recipients in a NF or ICF/MR see rule 7501.7.

The pharmacist shall not fill a prescription in a quantity different from that prescribed by the physician if payment is to be made by Medicaid except in an individual case when the quantity has been changed in consultation with the physician.

When the same drug in the same strength is prescribed for more than one member of a family at one time, the pharmacist must submit one prescription for each family member for payment purposes.

Claims for vendor payment are submitted to and processed by the fiscal agent only; there is no provision for direct reimbursement to recipients or to nursing facilities for payments they may make to a pharmacy or supplier.

7501.1 Beneficiaries Eligible for Medicaid and Medicare (01/01/2006, 05-24)

Beneficiaries who are entitled to Medicare benefits under Part A or enrolled in Medicare Part B, and who live in the service area of a Part D plan, are defined under Medicare rules at 42 CFR §423.30 as eligible for Part D. Vermont is included in the service area for several Part D plans. According to 42 CFR §423.906, Medicare is the primary payer for covered drugs for Part D eligible individuals. Medicaid will cover Part D copayments for beneficiaries under age 18 and women who are pregnant or in the 60-day post pregnancy period. Medicaid does not cover drugs in classes included in the Part D benefit. Medicaid provides secondary pharmacy coverage as described below for those eligible for both Medicare and Medicaid.

Part D is administered either through a prescription drug plan (PDP) or as a component of Part C, Medicare managed care, in a Medicare Advantage – Prescription Drug benefit (MA-PD).

The only drug classes that Medicaid continues to cover for those enrolled in a drug plan, if they are not covered by the PDP/MA-PD, are:

A. drugs for anorexia, weight loss, or weight gain (rule 7502.3);

B. single vitamins or minerals if the conditions described in rule 7502.4 are met;

C. over-the-counter prescriptions if the conditions described in rule 7502.5 are met;

D. barbiturates; and

E. benzodiazepines.

If a Part D eligible individual elects not to enroll in a PDP/MA-PD plan, or discontinues enrollment in such a plan, coverage for the drug classes listed above will end. Therefore, the individual will no longer have any pharmaceutical coverage from Medicaid. The only exception is an individual who has creditable coverage from a private insurer and has received a letter from that insurer stating that the existing coverage is creditable. These individuals will not be required to enroll in a Part D plan.

When an individual appeals a denial of coverage of a drug under a Part D or Part C plan, and has exhausted the plans appeal process through the Independent Review Entity (IRE) decision level, or the plans transition plan as approved by the Centers for Medicare and Medicaid Services (CMS), the individual may apply to the Office of Vermont Health Access (OVHA) for coverage of the drug if it is included in the Medicaid benefit (see rules 7502–7502.6). If the individuals prescriber documents medical necessity in a manner established by the director of the OVHA, and the process for documentation conforms with the pharmacy best practice and cost control program established under subchapter 5 of chapter 19 of Title 33, the drug shall be covered. A denial decision by OVHA is not subject to the provisions of rule 7104.

At the beginning of coverage under Medicare Part D, when an individual has applied for and has attempted to enroll in a Part D or Part C plan and has not yet received pharmaceutical coverage due to an operational problem with Medicare, or has otherwise not received coverage for the needed pharmaceutical, the necessary drugs will be covered, if OVHA finds that good cause and a hardship exist, until such time as the operational problem, good cause and hardship ends. The individual must have made every reasonable effort with CMS and the PDP, given the individual's circumstances, to obtain coverage. The intent of the good cause and hardship exception is remedial in nature and shall be interpreted accordingly. In general "good cause" shall include instances where the lack of coverage can not reasonably be considered the fault of the individual, and "hardship" shall include circumstances where alternative means for the coverage at issue are not reasonably available or will likely result in irreparable loss or serious harm to the individual. OVHA will make determinations of whether or not operational problems, good cause, or hardship exists for purposes of coverage.

7501.2 Payment Conditions (07/01/2000, 00-14)

Medicaid payment rates are established for covered services. For certain services, a recipient co-payment may be required for a portion of the Medicaid rate (see Obligation of Recipients).

7501.3 Payments for Prescribed Drugs (07/01/2000, 00-14)

Payment for prescribed drugs, whether legend or over-the-counter items, will be made at the lower of the price for ingredients plus the dispensing fee on file or the provider's actual amount charged which shall be the usual and customary charge to the general public.

7501.4 Price for Ingredients (11/12/2009, 09-27E)

Payment for the ingredients in covered prescriptions is made for two groups of drugs: multiple-source (i.e., therapeutically equivalent or generic drugs) and "other" drugs (i.e., single-source drugs [brand name] or drugs "other" than multiple-source).

A. For multiple-source drugs, the price for ingredients will be the lowest of:

   1. the CMS Federal Upper Limit (FUL), or
   2. the state Maximum Allowable Cost (MAC), or
   3. the Usual and Customary (U&C) charge, or
   4. the Average Wholesale Price (AWP) reduced by a percentage that is reflective of The Office of Vermont Health Access' appropriation in the state budget as passed by the Governor and/or the Legislature.

B. For "other" drugs, the price for ingredients shall be the lowest of:

1. the Usual and Customary (U&C) charge, or

2. the Average Wholesale Price (AWP) reduced by a percentage that is reflective of The Office of Vermont Health Access' appropriation in the state budget as passed by the Governor and/or the Legislature.

The exact payment methodology can be found in Attachment 4.19-B of the Vermont Medicaid State Plan.

When a physician certifies in his or her own handwriting that a specific brand of a multiple-source drug is medically necessary for a particular beneficiary, the price for ingredients will be calculated as for "other" drugs. The physician's handwritten phrase "brand necessary" or "brand medically necessary" must appear on the face of the prescription.

7501.5 Compounded Prescriptions (07/01/2000, 00-14)

Payment for compounded prescriptions is made at the lower of the actual amount charged or the price for ingredients plus the dispensing fee plus the compounding fee on file for each minute directly expended in compounding.

7501.6 Beneficiaries in Long-Term Care Facilities (01/01/2006, 05-24)

For those entitled to Medicare Part A or enrolled in Medicare Part B and enrolled in a Medicare prescription drug plan, this section applies to drugs not included in a Medicare-covered prescription drug class.

A pharmacy providing drugs to a psychiatric facility, a nursing facility, or an ICF/MR is reimbursed on the basis of cost of ingredients plus the dispensing fee per month for each prescribed drug furnished each recipient. The only exceptions are specific dosage forms including but not limited to aerosols, inhalants, liquids, topicals and injectables. Billing is done monthly with no increase allowed for additional time, services, or costs of containers which may result from use of the unit dose or any other system. The pharmacy may receive payment directly from these facilities for these extra costs and the facility may in turn include in its cost report such expenditure as an element of reasonable cost. The provider of drug items must accept, as payment in full, the amounts received from Medicaid.

7501.7 Unused Drugs From Long-Term Care Facilities (01/01/2006, 05-24)

Except for controlled substances, unused unit dose or modified unit dose medication that is in reusable condition, and which may be returned to a pharmacy pursuant to state laws, rules or regulations, shall be returned from long-term care facilities to the provider pharmacy.

When the primary payer is Vermont Medicaid, all returned medications must be credited to the Office of Vermont Health Access through its fiscal agent. The provider pharmacy will reverse the original claim and resubmit the actual amount dispensed.

7502 Prescribed Drugs (02/25/2012, 11-13)

Coverage is for any drug which is approved under the Federal Food, Drug, and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in section 1927(g)(1)(B)(i) of the Social Security Act.

The compendia are:

I. American Hospital Formulary Service Drug Information,

II. DRUGDEX Information System, and

III. United States Pharmacopeia-Drug Information (or its successor publications)

Coverage of all drugs is subject to the requirements of the Preferred Drug List (PDL).

Physicians and pharmacists are required to conform to Act l27 (l8-VSA-Chapter 9l), otherwise known as the Generic Drug Bill. In those cases where the Generic Drug Bill permits substitution, only the lowest priced equivalent in stock at the pharmacy shall be considered medically necessary. If, in accordance with Act l27, the patient does not wish to accept substitution, Medicaid will not cover the prescription.

7502.1 Smoking Cessation Products (02/25/2012, 11-13)

Coverage of over-the-counter and prescription smoking cessation products is provided to beneficiaries subject to the requirements of the PDL.

7502.2 Non-Drug Items (02/25/2012, 11-13)

Most non-drug items are not covered. Coverage is provided for Diabetic Supplies, Spacers, and Peak Flow Meters subject to the requirements of the PDL.

Some examples of excluded non-drug items include:

dentifrices and dental adhesives

baby oils

mouthwash

soaps and shampoos

food products and food supplements*

baby formula

sugar substitutes

topical antiseptics

throat lozenges

lotions, rubbing alcohol, and witch hazel

band-aids, gauze, and adhesive tape

ostomy deodorants, oral or external

placebo; all dosage forms

homeopathic medicines

alternative medicine/natural products (e.g. Ginseng, Ginko Biloba, etc.)

*Coverage for liquid nutritional supplements is subject to the requirements of the PDL. Prior authorization is required.

7502.3 Stimulants and Appetite Depressants (02/25/2012, 11-13)

Stimulants are covered only when used in accordance with the requirements of the Preferred Drug List.

Non-amphetamine-based weight-loss drugs (for example, Alli™, Xenical™) are covered with prior authorization.

7502.4 Vitamins and Minerals (02/25/2012, 11-13)

Select pre-natal vitamins are covered for pregnant and lactating women.

Generic multivitamins are covered.

Single vitamins B and D, and select minerals (e.g. calcium, iron) are covered when prescribed for the treatment of a specific disease; e.g. Injectable vitamin B–12 in the treatment of certain types of anemia.

7502.5 Over-the-Counter Drugs (02/25/2012, 11-13)

The following classes of over-the-counter drugs are covered in generic form only, where the attending physician has prescribed it as part of the medical treatment of a specific disease; for example, analgesics for the relief of arthritis pain, and laxatives for the bedbound:

- analgesics such as acetaminophen, aspirin and other non-steroidal anti-inflammatory products;
- fecal softeners such as those containing docusate;
- laxatives and antidiarrheals such as those containing loperamide;
- antacids;
- antihistamines;
- select cough and cold products; and
- other select products as determined by the DUR Board and included in the current list of categories of covered over-the-counter drugs.

7502.6 Family Planning Items (07/01/2006, 06-01)

Contraceptive drugs, supplies, and devices are covered when provided on a physicians order. Birth control pills may be dispensed in a quantity not to exceed a 92-day supply. Payments made for these items will be deemed to qualify for the increased federal financial participation contained in section 1903 (a)(5) of the Social Security Act.

7502.7 Vermont Prescription Monitoring System (10/29/2014, 14-07P)

All Medicaid participating providers who prescribe buprenorphine or a drug containing buprenorphine to a Vermont Medicaid beneficiary must query the Vermont Prescription Monitoring System the first time they prescribe buprenorphine or a drug containing buprenorphine for the patient and at regular intervals thereafter. Regular intervals must be no fewer than two times annually, and may include queries conducted prior to prescribing a replacement prescription. All Medicaid participating providers must query the Vermont Prescription Monitoring System prior to prescribing any replacement prescription for buprenorphine or a drug containing buprenorphine. As defined in 18 V.S.A. § 4290, replacement prescription means an unscheduled prescription request in the event that the document on which a patient's prescription was written or the patient's prescribed medication is reported to the prescriber as having been lost or stolen.

Dosage criteria, as approved by the Drug Utilization Review Board and meeting the requirements described in the Preferred Drug List, may only be exceeded with prior approval from the Chief Medical Officer of the DVHA or designee.

7503 Whole Blood (10/01/1983, 83-14)

Whole blood is provided without cost through the Red Cross Blood Program.

Costs of administering or tranfusing the blood are covered as an inpatient hospital service or physician's service.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7504.2 **Date of this Memo** 07/01/1999 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Does Medicaid cover diabetic counseling or education services?

ANSWER: Yes. Medicaid will cover one diabetic education course per lifetime provided by a hospital-sponsored outpatient program, in addition to 12 diabetic counseling sessions per calendar year provided by a certified diabetic educator.

Medicaid also covers one membership in the American Diabetes Association (ADA) per lifetime.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7504.2 **Date of this Memo** 02/10/2006 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Have there been any recent additions to coverage for medical supplies?

ANSWER: Yes. Medicaid will cover lamb's wool for beneficiaries who suffer from repeated ulcerations and need lamb's wool for padding and to wick moisture away from the skin. This does not require prior authorization, but does require a prescription by a physician.

Medicaid will pay for pull-up diapers for children with disabilities and daytime incontinence, ages 6-21, who are accepted into a comprehensive continence training program. Prior authorization is required.

7504 Medical Supplies (04/01/1999, 98-11F)

Medical supplies are non-durable items customarily used in conjunction with the care or treatment of a specific illness, injury or disability. [42 CFR 440.70(b)(3)]

7504.1 Eligibility for Care (04/01/1999, 98-11F)

Coverage of medical supplies is provided to beneficiaries of any age.

7504.2 Covered Services (04/01/1999, 98-11F)

Medical supplies necessary for the care and treatment of an eligible person and suitable for use in the home are covered. The full range of covered items falls into the general categories listed below. The list of general categories of items pre-approved for coverage is limited to[1] :

- adhesive tape and removers;
- antiseptics;
- briefs, diapers and underpads;
- catheters and catheter supplies;
- cotton and cotton-like products;
- diabetic diagnostics and daily care supplies;
- eye care and gauze pads and rolls;
- gloves;
- irrigation supplies;
- Low protein modified food products for treatment of an inherited metabolic disease, as required by Act 128 of the 1998 Legislative Session
- lubricating jelly;
- ostomy care supplies (including adhesives, irrigation supplies, bags and miscellaneous);
- respiratory/tracheostomy care supplies; and
- secondary dressings.

Medical supplies provided to a beneficiary by a physician or other provider may be covered if the supply is not expected to be included in the cost of the service provided.

7504.3 Conditions for Coverage (04/01/1999, 98-11F)

Medical supplies must be consistent with the patients medical condition and plan of care.

All items are subject to a maximum allowable payment amount.

Quantity limits may be exceeded with prior authorization.

[1] Some supplies in each category are subject to quantity limits. See the Provider Manual for specific quantity limitations.

In unusual circumstances, providers may purchase medical supplies for the personal use of a patient. When a hospital (inpatient or outpatient) provides medical supplies not otherwise reimbursed, payment will be made only to the hospital.

7504.4 Prior Authorization Requirements (04/01/1999, 98-11F)

Many medical supplies are subject to prior authorization review but they are not specified here because they are unusually numerous and they change frequently due to product change, new product availability, and the departments need for utilization management.

Prescribing physicians must submit a written request with pertinent diagnostic and clinical data to support the request. Some authorizations will be time-limited and will require periodic review including resubmission of medical necessity documentation.

7504.5 Non-Covered Services/Supplies (04/01/1999, 98-11F)

With the exception of medical supplies authorized for coverage via rule 7104, medical supplies that are not included in the categories of items specified under rule 7504.2, quantities of these supplies that exceed the limits specified in the Provider Manual, and medical supplies that do not meet criteria specified in rules 7504.2–7504.4, where applicable, are not covered.

In addition, medical supplies used by providers incidental to their practice shall not be billed separately.

7504.6 Qualified Providers (04/01/1999, 98-11F)

Medical supplies must be prescribed by a physician who is enrolled (either participating or non-participating) with Vermont Medicaid.

7504.7 Reimbursement (04/01/1999, 98-11F)

Reimbursement for medical supplies is described in the Provider Manual.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7505 **Date of this Memo** 07/15/2009 **Page** 1 of 1

This Memo: [ ] is New [X**] Replaces one dated** 07/15/03

This memo clarifies one of the conditions for coverage of wheelchairs or other mobility devices.

"Unable to ambulate by other means" is defined as unable to ambulate to accomplish MRADLs (mobility-related activities of daily living) as defined by Medicare (see below), to access authorized Medicaid transportation to medical services, or to functionally ambulate within the home environment and/or a radius of 100 feet. A wheelchair or mobility device is not covered when it is used primarily in educational or vocational environments, primarily used as transportation that otherwise could be accomplished in a vehicle, or is primarily useful for activities of daily living other than MRADLs.

For information on the scope of coverage for children under the federal requirements of EPSDT (Early Periodic Screening, Diagnosis, and Treatment), see 4100 and 7103.

Medicare definition of mobility-related activities of daily living:

The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:

- Prevents the patient from accomplishing an MRADL entirely, or
- Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or
- • Prevents the patient from completing an MRADL within a reasonable time frame.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7505.2 **Date of this Memo** 10/01/2008 **Page** 1 of 1

This Memo: [ ] is New [X**] Replaces one dated** 02/10/2006

QUESTION: Are there any recent additions to the list of covered durable medical equipment?

ANSWER: Yes.

- Medicaid will cover specially designed car seats for children with special health needs who meet specific clinical criteria. Prior authorization is required.
- Medicaid will cover an ultra violet light box when prescribed by a dermatologist (or physician skilled/knowledgeable in the treatment of dermatological disorders), for use in the home by beneficiaries with severe dermatological conditions. Prior authorization is required.
- Medicaid will cover standers for beneficiaries with severe neuromuscular health conditions when prescribed by a physician skilled/knowledgeable in rehabilitation. Prior authorization is required.
- Medicaid will cover adaptive weighted eating utensils for beneficiaries who have significant tremors that interfere with their ability to self-feed. These do not require prior authorization, but do require a prescription by a physician.
- Medicaid will cover special needs infant feeder bottles for infant beneficiaries with feeding/swallowing disorders to the extent that the lack of special needs infant feeder bottles would result in malnutrition, failure to thrive, aspiration, and respiratory infections. These do not require prior authorization, but do require a prescription by a physician and are subject to coverage limitations. Prior authorization is required for quantities in excess of the allowed amount.

7505 Durable Medical Equipment (DME) (04/01/1999, 98-11F)

Durable medical equipment (DME) is defined as equipment that will arrest, alleviate or retard a medical condition and is:

- primarily and customarily used to serve a medical purpose;
- lasting and able to withstand repeated use;
- generally not useful to a person in the absence of illness, injury or disability; and
- suitable for use in the home.

This definition is consistent with the Medicare definition and the Medicaid definition found at 42 CFR §440.70(b)(3).

7505.1 Eligibility for Care (04/01/1999, 98-11F)

Coverage for durable medical equipment is provided for beneficiaries of any age.

7505.2 Covered Services (04/01/1999, 98-11F)

Items of durable medical equipment that have been pre-approved for coverage are limited to:

- alternating pressure pumps and mattresses, gel and eggcrate mattresses, and decubitus care pads;
- ambulatory uterine monitoring devices;
- apnea monitors and related supplies and services;
- bathtub chairs and seats, including shower chairs and transfer benches;
- beds (hospital frame and mattress) and bed accessories for severe medical conditions, e.g., cardiac disease, chronic obstructive lung disease, spinal cord injuries including quadriplegia (Note: Craftomatic beds, oscillating/lounge beds, bed boards, ordinary mattresses, beds larger than single occupancy, tables and other bed accessories are not covered.);
- biosteogenic stimulators;
- blood glucose monitors;
- blood pressure cuffs/machines (including stethoscopes) when prescribed for patients who require frequent monitoring for a specific disease and when used as an alternative to home health nursing visits;
- rental of electric breast pumps and supplies for mothers of premature or critically-ill newborns;
- canes, crutches, walkers;
- circulatory aids;
- commodes (including bed pans, urinal pans and raised toilet seats) when the beneficiary is unable to access typical bathroom facilities;
- continuous passive motion devices (CPM) for homebound beneficiaries who have received total knee replacements;
- cushions and invalid rings;

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

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Reference 7505.3 **Date of this Memo** 10/01/2008 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Are any adaptive drink containers covered?

ANSWER: Yes. Medicaid will cover special needs infant feeder bottles for infant beneficiaries with feeding/swallowing disorders to the extent that the lack of special needs infant feeder bottles would result in malnutrition, failure to thrive, aspiration, and respiratory infections. These do not require prior authorization, but do require a prescription by a physician and are subject to coverage limitations. Prior authorization is required for quantities in excess of the allowed amount.

- diabetic equipment and supplies;
- digital electronic pacemaker monitor;
- external infusion pumps;
- heating pads/lights;
- lifts (hydraulic or electric, including one sling), if safe transfer between bed and a chair, wheelchair, or commode requires the assistance of more than one person;
- oxygen systems;
- portable sitz baths;
- protective helmets when the beneficiary is prone to falling (e.g. seizures, ataxia);
- repair of durable medical equipment including parts and labor;
- respiratory equipment, supplies and services;
- seat lift chairs when the beneficiary is unable to achieve a standing position without assistance;
- suction equipment;
- stethoscopes when acquisition is less costly than an alternative covered item or service;
- TENS/EMS units;
- traction equipment;
- vaporizers; and
- wheelchairs - see rule 7506.

7505.3 Conditions for Coverage (04/01/1999, 98-11F)

A physician who is enrolled with Vermont Medicaid must provide sufficient information to document the medical necessity of the item being prescribed. The medical necessity test can be met when the item is necessary to avoid bed or chair confinement.

The prescribing physician must have examined the beneficiary within a reasonable time period and/or have sufficient knowledge of beneficiary's condition to prescribe, or recertify the need for DME.

Payment will be made for one primary piece of equipment except if a beneficiary with an electric wheelchair needs a manual wheelchair to meet a therapeutic objective, a manual chair may also be approved with prior authorization.

Durable medical equipment must be suitable for use in the home.

Replacement of DME will be authorized when changing circumstances or conditions are sufficient to justify replacement with an item of different size or capacity, the useful lifetime has been reached, or when convincing evidence shows that replacement is necessary and appropriate.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7505.5 Date of this Memo 01/01/2013 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

QUESTION: Are any bathroom scales covered?

ANSWER: Yes. Medicaid covers bathroom scales for beneficiaries undergoing treatment for congestive heart failure.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7505.5 **Date of this Memo** 02/10/2006 **Page** 1 of 1

This Memo: [ ] is New [X**] Replaces one dated** 11/01/2002

QUESTION: Are any car seats covered?

ANSWER: Yes. Medicaid will cover specially designed car seats for children with special health needs who meet specific clinical criteria. Prior authorization is required.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7505.5 **Date of this Memo** 10/01/2008 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Are any eating utensils covered?

ANSWER: Yes. Medicaid will cover adaptive weighted eating utensils for beneficiaries who have significant tremors that interfere with their ability to self-feed. These do not require prior authorization, but do require a prescription by a physician.

Durable Medical Equipment (DME)

7505.4 Prior Authorization Requirements (04/01/1999, 98-11F)

Many items of durable medical equipment are subject to prior authorization review but they are not specified here because they are unusually numerous and they change frequently due to product change, new product availability, and the departments need for utilization management.

7505.5 Non-Covered Services (04/01/1999, 98-11F)

Unless authorized for coverage via rule 7104, items of durable equipment that are not covered include:

- adaptive drink containers/straw holders;
- bathroom scales;
- car seats;
- elevators and stair lifts;
- exercise equipment;
- exercise balls, weights, mats, and other equipment;
- equipment/supplies purchased for use in an institution such as a general hospital, mental hospital, psychiatric facility, nursing facility, or ICF/MR, as these costs are included in the facilitys reimbursement rate;
- equipment prescribed for educational or vocational purposes;
- equipment that is primarily hygienic in nature such as hand-held shower units;
- equipment that basically serves comfort or convenience functions for the beneficiary/caregiver;
- equipment used for environmental control or to enhance the environmental setting, e.g., air filters, conditioners, room/central humidifiers, vacuums, electric air cleaners;
- equipment and instruments intended for diagnostic purposes by health care specialists, or used within a hospital, or both;
- exercise equipment primarily for use within an institution, e.g., parallel bars;
- equipment that is precautionary in nature (e.g. medical alert bracelets, response systems);
- home modifications, including access ramps;
- household equipment and supplies such as hypo-allergenic bedding, ramps, switches, tableware, eating utensils;
- items used for cosmetic purposes such as wigs;
- mobile geriatric chairs;
- personal computers and printers;
- reachers;
- repair of rental equipment or equipment covered under warranty;
- rollabout chairs;
- telephone alert systems and telephone alarms;
- toys;
- two-wheeled motorized vehicles; and

- whirlpool pumps.

7505.6 Qualified Providers (04/01/1999, 98-11F)

DME providers must be licensed, registered and/or certified by the state (where appropriate) and must be enrolled with Vermont Medicaid.

DME providers are expected to maintain adequate and continuing service-support for Medicaid beneficiaries.

7505.7 Reimbursement (04/01/1999, 98-11F)

Reimbursement for durable medical equipment is described in the Provider Manual.

The department is the owner of all purchased equipment. Such equipment may not be resold. At the discretion of the commissioner or the commissioners designee, durable medical equipment may be recovered for reuse or recycling when the original beneficiary no longer needs it. When serviceable equipment is no longer needed or appropriate for a beneficiary, the beneficiary should notify the department and request permission to dispose of the equipment.

7506 Wheelchairs, Mobility Devices and Seating Systems (04/01/1999, 98-11F)

Wheelchairs and mobility devices are items of durable medical equipment that enable mobility for those beneficiaries unable to ambulate by other means. A mobility device is an item that serves the same purpose as a wheelchair but may be an appropriate alternative for a beneficiary otherwise requiring a wheelchair.

A seating system must contain a seat and/or back with one other positioning component. It is assembled on a mobility base (frame/wheels) to promote neutral alignment and/or accommodate a fixed postural deformity in order to improve function.

Customizing is defined as making significant alterations or modifications to a component that are not anticipated in the manufacturers design or require fabrication of another component or hardware in order to adapt the seating system to a beneficiary or to the wheelchair.

These definitions of a wheelchair and a mobility device are consistent with the federal definition found at 42 CFR §440.70(b)(3).

7506.1 Eligibility for Care (04/01/1999, 98-11F)

Coverage for wheelchairs, mobility devices, and seating systems is provided for beneficiaries of any age.

7506.2 Covered Services (04/01/1999, 98-11F)

Wheelchairs, mobility devices, seating systems, and related services that have been pre-approved for coverage are limited to:

Rental of Wheelchairs Payment will be made for rental of a wheelchair: (a) while waiting for purchase/repair of a custom chair, when there is no other available option; or (b) for documented appropriate, short-term, acute medical conditions. Documentation is required to show that the beneficiary would have substantial chair or bed confinement without a wheelchair.

Purchase of Manual Wheelchairs Payment will be made for standard manual wheelchairs for beneficiaries who have documented long-term medical needs and are capable of upper body function sufficient to self-propel.

Purchase of Custom Wheelchairs, Battery-Operated Wheelchairs, Three-Wheeled Power Vehicles, and Other Mobility Devices Payment will be made for a custom-manual wheelchair, a battery-operated wheelchair, a three-wheeled power vehicle, or other mobility device when a beneficiary's needs cannot be reasonably met by the provision of a standard manual chair.

Purchase of Replacement Wheelchair Payment will be made for replacement wheelchairs for beneficiaries with specific documented growth needs; for beneficiaries with a change in medical status that necessitates replacement of equipment; for loss; or, for replacement of current equipment when, as a result of normal wear and tear, it no longer safely addresses the medical needs of the beneficiary.

Seating Systems Covered items are manufactured seating systems, seating systems that consist entirely of components that have been custom-fabricated by the DME provider, and seating systems that consist of both manufactured components and components custom-fabricated by the DME provider for use in a wheelchair.

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation **[ ] Medicaid Covered Services Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 7506.3 **Date of this Memo** 07/15/2003 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

This memo clarifies one of the conditions for coverage of wheelchairs or other mobility devices.

"Suitable for use in the home" means a wheelchair or other mobility device suitable for use in environments routinely encountered by the individual in the course of accomplishing their basic activities of daily living (ADLs), including but not limited to the home environment, except when the wheelchair or mobility device is used primarily in educational or vocational environments, or primarily used as transportation.

Payment will be made for a seating system and/or any required accessories for an individual residing in a long-term care facility when the system is prescribed by a registered physical or occupational therapist trained in rehabilitative equipment and the system is so unique to the individual that it would not be useful to other nursing home residents. Cushions not integral to the seating system are not covered.

When the department has purchased a seating system for an individual residing in a long-term care facility and that individual moves to a new living arrangement, the department will purchase from the facility, at the net book value, the component of the wheelchair purchased by the facility.

Labor Reimbursement for labor associated with custom fabrication of a seating system or customizing a seating system will be made to the DME provider up to the limit of five hours.

Repairs Repair to damaged or worn out equipment is covered when the equipment is not under warranty.

7506.3 Conditions for Coverage (04/01/1999, 98-11F)

The provisions of rule 7505 regarding durable medical equipment apply to wheelchairs.

7506.4 Prior Authorization Requirements (04/01/1999, 98-11F)

Prior authorization is required for rental of a wheelchair beyond three months.

Prior authorization is required for the purchase of all wheelchairs and mobility devices except the initial purchase of a standard manual wheelchair with sling seat.

Prior authorization is required for wheelchair replacement. When an individual who resides in a long-term care facility moves to a new living arrangement and requires a wheelchair that is not available in the new residence, the department will authorize coverage for a new wheelchair or purchase, at the net book value, the wheelchair provided by the facility from which the individual moved.

Prior authorization is required for wheelchair repairs costing more than $300. Requests for prior authorization should include the date of purchase and specification of anticipated parts and labor costs. Repair invoices must include an itemized list of components, costs, and labor charges. Equipment guarantees, warranty, and any available third party liability must be utilized before billing Medicaid.

Prior authorization is required for the labor cost of repairs where parts are under warranty.

7506.5 Non-Covered Services (04/01/1999, 98-11F)

With the exception of equipment or services authorized for coverage via rules 7104, equipment or services not included under rule 7506.2 and equipment or services that do not meet criteria specified in rules 7506.2–7506.4, where applicable, are not covered.

In addition, no payment will be made for rental of a wheelchair when a less expensive equipment/service is available and appropriate for the beneficiary's medical needs (for example, crutches for a fractured ankle when the beneficiary has upper body function).

Payment will not be made for:

- back-up equipment,
- custom-colored wheelchairs or accessories,
- customized seating systems for mobility devices other than wheelchairs, and
- costs associated with repair or adjustments to the original wheelchair and related items within 60 days of purchase or other implied or expressed warranty.

Payment will not be made to DME suppliers for costs associated with fitting/evaluation of a seating system. These costs are included in the initial reimbursement for the item.

7506.6 Qualified Providers (04/01/1999, 98-11F)

DME providers must be licensed, registered and/or certified by the state (where applicable) and be enrolled with Vermont Medicaid.

DME providers are expected to maintain adequate and continuing service-support for Medicaid beneficiaries.

7506.7 Reimbursement (04/01/1999, 98-11F)

Reimbursement for durable medical equipment is described in the Provider Manual.

The department is the owner of all purchased equipment. Such equipment may not be resold. At the discretion of the commissioner or the commissioners designee, durable medical equipment may be recovered for reuse or recycling when the original beneficiary no longer needs it. When serviceable equipment is no longer needed or appropriate for a beneficiary, the beneficiary should notify the department and request permission to dispose of the equipment.

7507 Augmentative Communication Devices/Systems (04/01/1999, 98-11F)

An augmentative communication device or system transmits or produces messages or symbols in a manner that compensates for the disability of a beneficiary with severe communication impairment. It is a specialized prosthetic device consistent with the federal definition found at 42 CFR 440.120(c).

7507.1 Eligibility for Care (04/01/1999, 98-11F)

Coverage for augmentative communication devices or systems is provided to all Medicaid beneficiaries.

7507.2 Covered Services (04/01/1999, 98-11F)

Augmentative communication devices or systems that have been pre-approved for coverage are limited to:

- non-powered devices;
- battery-powered systems such as specialized typewriters;
- electronic or computerized devices, such as electrolarynges, portable speech devices, hand-held computers and memo pads, typewriter-style communication aid with LCD and/or synthesized speech, electronic memo writers with key or membrane pad, customized assisted keyboards, scanning devices including optical pointer, single switch, mouse, trackball, and/or Morse code access, laptop or micro computers and computer software;
- modification, programming, or adaptation of Medicaid-purchased devices when provided by qualified speech/language providers; and,
- repairs/service on Medicaid-purchased items after one year when the repair/service is provided by qualified vendors.

7507.3 Conditions for Coverage (04/01/1999, 98-11F)

Payment will be made for purchase or rental of augmentative communication devices or systems to assist a beneficiary in communication when the impairment prevents writing, telephone use, or talking.

Augmentative communication prescriptions must take into account the beneficiary's current and future needs.

An augmentative communication device or system will be approved only if the device/system will be used to meet specific medical objectives or outcomes. The beneficiarys cognitive level of functioning will be taken into consideration when matching the device to the beneficiary.

Before authorizing purchase of selected augmentative communication devices or systems, the department may require a trial rental period. Factors that will be considered in determining whether a trial period will be required include cost and level of technology of the device/system, anticipated length of need, and availability of rental equipment.

Purchase of the rented device or system will be considered only after the beneficiary has demonstrated success in meeting the majority of medical outcomes associated with short-term goals as specified in the medical necessity documentation.

Payment will be made for one primary piece of medical equipment; duplicate services/equipment in multiple locations will not be covered.

Coverage for replacement equipment will be provided only when the existing device or system no longer effectively addresses the beneficiary's needs.

All devices or systems must carry a one-year warranty.

7507.4 Prior Authorization Requirements (04/01/1999, 98-11F)

Prior authorization is required for the rental or purchase of all augmentative communication devices or systems.

The department reserves the right to request a second opinion or additional evaluations for the purpose of clarifying medical objectives or outcomes.

7507.5 Non-Covered Services (04/01/1999, 98-11F)

Unless authorized for coverage via rule 7104, environmental control devices, such as switches, control boxes, or battery interrupters, and similar devices that do not primarily address a medical need are not covered.

Initial purchase of the device or system will include any training provided by the manufacturer or supplier. Additional training by the manufacturer or supplier is not covered. However, if additional training is necessary for the beneficiary, it may be obtained through speech therapy services.

7507.6 Qualified Providers (04/01/1999, 98-11F)

Providers must be licensed, registered and/or certified by the state (where applicable) and be enrolled with Vermont Medicaid.

Vendors are expected to maintain adequate and continuing service support for Medicaid beneficiaries.

7507.7 Reimbursement (04/01/1999, 98-11F)

The department is the actual owner of all purchased equipment. Such equipment may not be resold. At the discretion of the commissioner or the commissioners designee, augmentative communication devices may be recovered for reuse or recycling when the original beneficiary no longer needs it. When serviceable equipment is no longer needed or appropriate for beneficiaries, they should notify the department and request permission to dispose of the equipment.

Reimbursement for augmentative communication devices or systems is described in the Provider Manual.

7508 Prosthetics Devices (04/01/1999, 98-11F)

A prosthetic device is a replacement, corrective or supportive device to: 1) artificially replace a missing portion of the body; 2) prevent or correct physical deformity or malfunction; or 3) support a weak or deformed portion of the body. Prosthetics include orthotics. This definition is taken from the federal definition found at 42 CFR §440.120(c).

7508.1 Eligibility for Care (04/01/1999, 98-11F)

Coverage of a prosthetic device is available for beneficiaries of any age.

7508.2 Covered Services (04/01/1999, 98-11F)

Items and services that have been pre-approved for coverage are limited to:

- artificial limbs;
- artificial larynx;
- breast forms;
- prosthetic shoes;
- ostomy products;
- parenteral and enteral nutrition services;
- prosthetic eyes;
- braces and trusses for the purpose of supporting a weak or malformed body member;
- orthotic shoes as an integral part of a leg brace or affixed to an integral part of a leg brace;
- aircast splints;
- foot abduction rotation bars;
- shoe lifts, elevation heels, wedges; and
- molded orthopedic shoes when prescribed for diabetes, severe rheumatoid arthritis, ischemic, intractable ulcerations, congenital defects, and deformities due to injuries.

The complete policy regarding hearing, vision, vocal, and dental prostheses is contained in rules 7315, 7316, 7507 and 7312–7314.6, respectively.

7508.3 Conditions for Coverage (04/01/1999, 98-11F)

Prosthetic devices must be prescribed by a physician or podiatrist who is enrolled with Vermont Medicaid.

Devices must be appropriate for beneficiary's age, gross and fine motor skills, developmental status, mental functioning, and physical condition.

Duplicate items are not covered (e.g., two pairs of customized orthotics).

Coverage for Medicaid-approved shoes is limited to two pairs per adult beneficiary per calendar year unless a prior authorization review finds special circumstances that warrant additional pairs.

Custom-made arch supports prescribed by a physician or podiatrist are covered when they meet the definition of an orthotic (i.e., are used as a brace, truss or other similar device for the purpose of supporting a weak or deformed body member).

7508.4 Prior Authorization Requirements (04/01/1999, 98-11F)

Many items of prosthetic/orthotic equipment are subject to prior authorization review but they are not specified here because they are unusually numerous and they change frequently due to product change, new product availability, and the department's need for utilization management. The Provider Manual contains a detailed list of prosthetic/orthotic equipment, their codes, and fee schedule. It also indicates which prosthetic/orthotic equipment codes require prior authorization.

7508.5 Non-Covered Services (04/01/1999, 98-11F)

Unless authorized for coverage via rule 7104, items that are not covered include:

- orthopedic shoes when prescribed for flat feet; and
- orthotics/prosthetics that primarily serve to address social, recreational, or other factors and do not directly address a medical need.

7508.6 Qualified Providers (04/01/1999, 98-11F)

Providers of prosthetic and orthotic devices must be licensed, registered and/or certified by the state (where required) and be enrolled with Vermont Medicaid.

7508.7 Reimbursement (04/01/1999, 98-11F)

Reimbursement for prosthetic and orthotic devices is described in the Provider Manual.

Prosthetic/orthotic suppliers may not bill Medicaid for items furnished by hospitals to their in- or out-patients. Hospitals cannot bill separately for prosthetic or orthotic supplies.

The cost of modifications made within 60 days of purchase is included in the initial reimbursement of the orthotic or prosthetic.

7601 Long-Term Care Services (02/06/10, 09-07)

These regulations apply to all long-term care services for Medicaid beneficiaries of any age. For beneficiaries age 18 or over, regulations promulgated by the Department of Disabilities, Aging and Independent Living (DAIL) "Choices for Care 1115 Long-Term Care Medicaid Waiver" program (Social Security Act Section 1115 Demonstration Project Number 11-W-00191/1) shall be controlling if they conflict with the provisions in this chapter (7601–7606).

The Medicaid Program (Title XIX) includes long-term care services provided to eligible beneficiaries in the following settings.

A. Nursing Facilities (NF's)

A Nursing Facility provides, directly or by contract, room, board, skilled nursing and rehabilitation services on a 24–hour a day basis to assist beneficiaries to reach their optimal level of functioning.

All nursing facilities, pursuant to Section 1910(2) of the Social Security Act, have been certified for participation in Medicare, or if not participating in Medicare, have been continuously certified since July 1, 1980 for participation as a nursing facility as evidenced by a valid certification agreement on file with the Office of Vermont Health Access.

An out-of-state nursing facility must be participating in that state's Medicaid program as well as enrolled as a Vermont Medicaid provider. An in-state nursing facility (or distinct part of a facility) must be licensed by DAIL and enrolled as a Vermont Medicaid provider, in order to be reimbursed.

(1) Rehabilitation Center Services

Coverage of rehabilitation center services is limited to Medicare-certified nursing facilities, licensed by, and approved for participation by the state in which the facility is located and enrolled as a Vermont Medicaid provider. These services include intensive sensory stimulation; intensive physical, speech and occupational therapy; adjustment counseling; training in the use of prosthetics, orthotics and durable medical equipment; and other medical services needed to improve the patient's daily living skills and/or to facilitate recuperation from disease, injury or medical event. Care must be supervised by physician specialists. The purpose of rehabilitation center services is to restore a beneficiary's functional abilities to the highest practical level of physical and/or mental self-sufficiency which will prepare the beneficiary for discharge. The discharge plan will provide for the active participation and training of family members, if appropriate.

Coverage is limited to one year unless an extension beyond one year is granted by DAIL when documented medical evidence shows that the beneficiary is continuing to demonstrate significant physical and/or mental progress and can reasonably be expected to be discharged to the setting for care established in the discharge plan. Under no condition will authorization be made beyond two years.

B. Intermediate Care Facilities for the Mentally Retarded (ICF/MR's)

A public or private institution (or distinct part thereof) certified for CMS participation by DAIL's Division of Licensing and Protection, for the provision of Intermediate Care Facility services for the Mentally Retarded (ICF/MR) as evidenced by a valid certification agreement on file with the Office of Vermont Health Access executed under 1902(a)(27) of the Social Security Act and 42 CFR 442, Subparts A, B, C, E and G. An ICF/MR provides, directly or by contract, health-related care and services to individuals with mental retardation.

C. Home and Community-Based Services

Long-Term Care Services

Home and Community-Based Services include long-term care services provided in a home setting or an enhanced residential care setting. An individualized written service plan shall be developed for each participant. Services may include assistance with Activities of Daily Living, Instrumental Activities of Daily Living, Adult Day Service, Respite, Companion Service, Personal Emergency Response System, Home Modification/Assistive Devices, and other such services as DAIL may include (Choices for Care Regulations).

7602 Supplementation Prohibition (02/06/10, 09-07)

Federal regulations require all Medicaid providers of long-term care services to accept the Medicaid payment as payment in full. For example, if a facility elects to serve Medicaid beneficiaries and the facility's customary charge for a semi-private room is $250.00, but the Medicaid payment is $200.00 per day, the Medicaid payment must be accepted as payment in full. The facility cannot collect any supplemental amount for the semi-private room from the beneficiary or anyone else acting on behalf of the beneficiary. If the beneficiary, or anyone acting on behalf of the beneficiary, wishes to have a private room, the facility cannot charge more than the difference between the charges for a semi-private and a private room. In no case can the total payments for a private room exceed the charge for a private room.

Federal regulations also describe specific items and services for which a facility may charge residents extra. Beyond these items and services, supplementation by the beneficiary, family, friends or any other source is prohibited.

Federal regulations also require that Medicaid beneficiaries be informed, in writing, by the facility, at the time of admission to the nursing facility or when they become eligible for Medicaid, of the items and services that the facility offers and for which the beneficiary may be charged, as well as the amount of charges for those services. The Division of Licensing and Protection within the DAIL is responsible for enforcing this regulation.

7603 Services Covered in a Nursing Facility (02/06/10, 09-07)

The following covered services are included in the per diem rates for nursing facilities.

A. Room and board;

B. Required nursing services (except private duty nurses);

C. Therapy services (physical, occupational, inhalation, recreational, etc.) furnished on the premises by staff employed by the facility;

D. Modification of diet (i.e., salt-free, low-fat, diabetic and other special diets and including sugar substitutes and food supplements).

E. Other special care services including, but not limited to: handfeeding, incontinence care, total care, full-time care, etc.;

F. Washing personal clothing and provision of clean bedding;

G. Bathroom supplies including toothbrush, comb, soap, shampoo, tissue, rubbing alcohol, toothpaste, lotions, talcums and similar preparations used in daily care;

H. Bedding, sheets, disposable pads, etc.;

I. All prescribed over-the-counter drugs;

J. Sterile water, saline solution, etc.;

K. All medical supply items ordered by the physician; and

L. Use of durable medical equipment with whatever frequency is medically indicated.

7603.1 Drugs in a Long-Term Care Facilities (02/06/10, 09-07)

For those Medicaid beneficiaries entitled to Medicare Part A or enrolled in Medicare Part B and enrolled in a Medicare prescription drug plan, this section applies only to drugs not included in a Medicare-covered prescription drug class.

Drugs prescribed by the attending physician for a beneficiary in a nursing facility or an ICF/MR are covered in the same manner as for a beneficiary living in the community. Covered drugs are those available only with a prescription, obtained from a participating pharmacy, and billed directly by that pharmacy to the Medicaid fiscal agent; the pharmacy cannot bill the nursing facility and the facility then re-bill Medicaid. An exception is made for a Medicare-participating nursing facility which must collect first from Part A for covered drugs supplied as an ancillary service during the period a beneficiary is receiving nursing facility benefits under Medicare Part A.

All prescribed over-the-counter drugs for their residents are to be furnished by each nursing facility or ICF/MR. The facility will obtain these drugs from a pharmacy or drug wholesaler and enter the charges incurred in the cost report submitted for purposes of calculating the per diem rate. The facility shall not make a charge either to the program or to the beneficiary for prescribed over-the-counter drugs.

A pharmacy may, however, receive payment directly from a nursing facility or ICF/MR for reasonable costs incurred for unit dose or other systems, consulting services, or other costs incurred by the pharmacy in complying with Medicaid Rule 7501.7 and the facility shall include this cost in its cost report.

7603.2 Personal Comfort Items (02/06/10, 09-07)

Radio, television, telephone, air conditioners, beauty and barber services, and similar personal comfort items are excluded from coverage under Medicaid. The beneficiary may be charged for any personal comfort item when the beneficiary has requested it and has been advised that he or she will be charged.

The facility may also charge the beneficiary for store items secured on the beneficiary's behalf such as magazines, newspapers, candy, tobacco, dry cleaning, denture cream, hairbrush, and deodorant.

7603.3 Ancillary Services in a Nursing Facility (02/06/10, 09-07)

A nursing facility participating in Medicare must bill under Medicare Part B for the following services provided to beneficiaries when that beneficiary has exhausted his or her extended care coverage under Medicare Part A. For beneficiaries not covered by Medicare, billing Medicaid for these ancillary services is allowed.

A. diagnostic X-ray, diagnostic laboratory and other diagnostic tests;

B. X-ray, radium and radioactive isotope therapy;

C. surgical dressings, splints, cast and other devices used to reduce fractures;

D. prosthetic devices;

E. leg, arm, back and neck braces;

F. "outpatient" physical therapy and speech therapy services. Payment for outpatient physical therapy and speech therapy services requires certification by a physician that:

(1) Therapy services are or were required on an outpatient basis; and

(2) A plan for furnishing the therapy services is or was established and reviewed periodically by the physician; and

(3) The services are or were furnished while the patient was under care of a physician.

Therapy services furnished by a provider’s employees to its residents may not be billed as outpatient services.

A nursing facility participating in Medicare may provide, under arrangements with another provider, certain covered outpatient services to its residents. Under the arrangements the nursing facility must exercise professional responsibility over the arranged-for services. The services would be treated just as though they were furnished directly by the nursing facility.

7604 Duration of Coverage (02/06/10, 09-07)

Payment on behalf of an eligible beneficiary, for the period(s) the beneficiary is determined to be in need of institutional care, will begin on admission to the facility or the first day of Medicaid eligibility, whichever is later. Payment will end on the day before the day of discharge or death, the last day the beneficiary is determined to need institutional care or the last day of eligibility, whichever is earliest.

Payment will end for any absence from a facility for an inpatient stay in another medical facility (i.e., hospital, psychiatric hospital, another nursing facility except as provided below (7604.1.B).

7604.1 Leave of Absence from a Nursing Facility (02/06/10, 09-07)

A. Home Visit

Payment to a nursing facility on behalf of an eligible Medicaid beneficiary is continued during an absence for the purpose of a "home visit" (not including hospital stays) for up to 24 home visit days in a calendar year. A home visit is defined as a visit that includes an overnight stay. Such absences must be included in the beneficiary's plan of care.

B. Hospitalization

Pursuant to the Nursing Home Residents' Bill of Rights (33 VSA §§ 7301–7306), a Medicaid beneficiary has the right to retain his or her bed in a nursing facility while absent from the facility due to hospitalization provided such absence does not exceed ten (10) successive days.

Medicaid payment will be made to a nursing facility that is not a swing bed facility for up to a maximum of six (6) successive days when the bed of a beneficiary is retained because the beneficiary is admitted as an inpatient to a hospital subject to the following conditions:

(1) the nursing facility would otherwise be at its maximum licensed occupancy if the operator were not obligated to hold the bed open,

(2) the beneficiary continues to meet Medicaid eligibility criteria,

(3) the beneficiary has been an inpatient resident of the nursing facility and was admitted directly to the hospital.

(4) the nursing facility has a valid provider agreement in effect on the dates of service for which payment is made,

(5) the beneficiary's attending physician attests that the beneficiary is expected to be readmitted to the nursing facility from the hospital in ten (10) days or less, or, upon notice supplied by the hospital discharge planning unit to the nursing facility that the beneficiary will be discharged with an absence which shall not exceed ten successive days, and

(6) documentation as required above (#3) above is provided to OVHA, and is on file at the nursing facility.

Payment for the days the bed is retained for the beneficiary will be made at the certified Medicaid per diem rates established for the nursing facility reduced by the amount, if any, of the beneficiary's share.

No payment will be made when a physician or hospital discharge planning unit makes a determination that the beneficiary will be hospitalized for more than ten (10) successive days, will never return to the nursing facility, or the beneficiary or legal representative agree to waive the right to have his or her bed retained.

When a redetermination about the length of stay is made because of a change in the beneficiary's medical condition, payment will be made in accordance with the redetermination.

Each day reimbursed under this regulation is counted as a patient day for cost reporting purposes and must be reported separately from home visit days.

7604.2 Leave of Absence from an ICF/MR (02/06/10, 09-07)

Payments to an ICF/MR on behalf of an eligible beneficiary is continued for an absence of up to fifteen (15) days per quarter or sixty (60) days per year for the purpose of "home visit" providing it is consistent with and part of the beneficiary's current service agreement. Approval for an absence for the purpose of a "home visit" in excess of fifteen (15) days per quarter or sixty (60) days per year shall be obtained in advance from DAIL.

Medicaid payment shall be made to an ICF/MR for an eligible beneficiary during a leave of absence, subject to the following conditions:

A. Any day for which the facility is paid to hold a bed open must be counted as a patient day and the revenue must be accounted for as a patient revenue.

B. The day of departure shall be counted as one day of leave and the day of return shall be counted as one day of inpatient care.

C. The facility shall hold the bed vacant during leave.

D. The beneficiary's return from leave shall not be followed by discharge within 24 hours.

E. The facility shall identify the inclusive dates of leave in the manner designated by DAIL.

F. Leave shall be terminated on the day of death.

7605 Authorization for Long-Term Care (02/06/10, 09-07)

A. Nursing Facilities

After DAIL has determined clinical eligibility for long-term care, the Department for Children and Families — Economic Services Division (ESD) determines financial eligibility for long-term care. ESD then furnishes written authorization to long-term care service providers of financial eligibility for long-term care. Eligibility for long-term care is based on financial eligibility, admission-discharge status, and clinical eligibility as determined by DAIL. Updated or revised authorizations are issued whenever one of these factors changes. The determination by DAIL shall control notwithstanding any statements by a physician or other health care professional to the contrary. Where applicable, such statements shall be reviewed by DAIL in making its determination.

Authorization for payment will be made on behalf of an eligible beneficiary based on a determination of financial eligibility (Medicaid Rules 4100–4400), and clinical eligibility made by DAIL (Choices for Care 1115 Long-Term Care Medicaid Waiver Regulations, Section IV.B).

No Medicaid payment will be made for services provided by any out-of-state nursing facilities, other than those mentioned below, unless the facility has been enrolled by the OVHA, and the admission authorized by DAIL.

Some out-of-state nursing facilities are regarded the same as any participating Vermont facility. No prior authorization is needed. The current list of approved facilities can be found on the DAIL web site (http://www.dlp.vermont.gov/other/pre-approved-out-of-state-facilities) or can be requested from the DAIL.

Information regarding nursing facility care in a hospital (swing beds) is located in Medicaid Rule 7606.

(1) Level of Care

DAIL has review authority for all nursing facilities. The determination by DAIL shall control notwithstanding any statement by a physician or other health care professional to the contrary. DAIL shall consider:

The need for a beneficiary's admission to the facility.

The need for continued stay.

The level of care required.

The appropriateness and quality of care received.

(2) Pre-Admission Screening and Resident Review (PASARR)

Pre-admission Screening and Resident Review shall be completed for certain individuals who have been or will be admitted to a nursing facility, as required by federal regulations at 42 CFR §483(c). PASARR shall determine if a person with a diagnosis of mental illness, mental retardation or a related condition requires the care provided in another type of facility, home and community-based care, or specialized services while residing in a nursing facility. The Department of Mental Health shall be responsible for PASARR for those individuals suspected of having a mental illness, or with a diagnosis of mental illness. DAIL shall be responsible for PASARR for those individuals suspected of having mental retardation or a related condition, or with a diagnosis of mental retardation or a related condition.

(3) Post-Admission Review

Clinical eligibility for any Medicaid beneficiary or applicant residing in or admitted to a nursing facility shall be determined by DAIL within ten (10) days of notification of admission or notification of application. If the beneficiary is found medically ineligible, he/she will be notified by the DAIL.

(4) Children in Long-Term Care Facilities

Least restrictive alternate living situations shall be utilized for children under age 18. When necessary, children may be served by nursing facilities in Vermont. All out-of-state nursing facilities are covered only after obtaining prior approval from DAIL. Payment for out-of-state nursing facilities for children will be covered only if there is no less restrictive placement in Vermont, only if deemed necessary by DAIL, and only if the facility is enrolled as a Vermont Medicaid provider.

B. ICF/MRs

Decisions regarding initial admission and continued stay in an ICF/MR shall be made DAIL in accordance with appropriate state and federal regulations.

7606 Nursing Facility Care in Hospitals — Swing Beds (02/06/10, 09-07)

Payment may be made on behalf of a Medicaid beneficiary who remains residing in a hospital upon determination by the Department of Disabilities, Aging, and Independent Living (DAIL) that he/she no longer needs hospital care but has been found in need of nursing facility level of care (swing bed). Such payment will be made only if the following conditions are met:

A. The beneficiary is eligible for Medicaid during the period for which reimbursement is requested.

B. The beneficiary is determined by the appropriate Utilization Review authority to be in need of nursing facility care for this period.

C. The beneficiary has a qualifying inpatient hospital stay in the hospital seeking nursing facility payment under these provisions.

D. The hospital's documentation shows a concerted and continuous effort to secure appropriate alternative placement for the beneficiary. No payment will be made in instances in which the Office of Vermont Health Access establishes that discharge planning efforts have been inadequate; where payment has already been made, recovery will be sought.

E. The beneficiary or anyone acting on his or her behalf has not declined an available bed in an appropriate participating long-term care facility in the area.

The per diem rate is all inclusive and includes the covered services as specified in Medicaid Rule 7603. For beneficiaries covered by Medicare, billing for ancillary services covered by either Part A or Part B is allowed. For beneficiaries not covered by Medicare, billing to Medicaid for ancillary services listed in Medicaid Rule 7603.3 is allowed.

Out-of-state pre-approved hospitals with swing bed status are regarded the same as any participating Vermont facility. The current list of approved facilities can be found on the DAIL web site (http://www.dlp.vermont.gov/other/pre-approved-out-of-state-facilities) or can be requested from the DAIL.

7700 Pharmacy Administration (11/01/2008, 08-03)

7701 Pharmaceutical Manufacturer Fee (11/01/2008, 08-03)

Act 80, of the 2007 legislative session, an Act relating to increasing transparency of prescription drug pricing and information, established a manufacturer fee under 33 V.S.A. § 2004. A fee shall be collected annually by the Agency of Human Services from each pharmaceutical manufacturer or labeler of prescription drugs that are paid for by the Office of Vermont Health Access for individuals participating in Medicaid, the Vermont Health Access Plan (VHAP), Dr. Dynasaur, VPharm, VHAP-Pharmacy, VScript, or VScript Expanded. The fee shall be 0.5 percent of the previous calendar year's prescription drug spending by the office and shall be assessed based on manufacturer labeler codes as used in the Medicaid rebate program. The fee shall be deposited in the evidence-based education and advertising fund established by 33 V.S.A. § 2004a. This fee shall fund activities, including the evidence-based education program, established by 18 V.S.A. § 4622.

The evidence-based education program will provide information and education on the therapeutic and cost-effective use of prescription drugs, as well as the collection and analysis of information on pharmaceutical marketing activities under sections 4632 and 4633 of Title 18, and analysis of drug data needed by the attorney general's office for enforcement activities concerning prescription drugs.

The OVHA shall annually provide the manufacturer or labeler with a written bill in the amount of 0.5 percent of the payments made on claims submitted during the previous calendar year regarding the manufacturer's or labeler's prescription drugs. This amount will be based on paid claims data (data used to reimburse pharmacies) under the state's programs. The manufacturer or labeler shall remit the invoiced amount according to instructions provided by OVHA.

In the event the manufacturer or labeler believes an error in billing has occurred, the manufacturer or labeler must notify the OVHA in writing within thirty days of the receipt of the bill. This notification must be accompanied by written materials setting forth the basis for the requested review. The billing data will be verified and adjusted if appropriate, which may include a credit as to the amount of the bill, or a refund of amounts paid.

The OVHA shall maintain electronic claims records for five quarters after the end of a billing calendar year that will permit the manufacturer labeler to verify through an audit process the billing invoices provided by the OVHA.

7702 Telemonitoring (10/29/2014, 14-05P)

Home telemonitoring is a health service that requires scheduled remote monitoring of data related to an individual's health, and transmission of the data from the individual's home to a licensed home health agency. Scheduled periodic reporting of the individual's data to the licensed physician is required, even when there have been no readings outside the parameters established in the physician's orders. Telemonitoring providers must be available 24 hours per day, 7 days a week.

7702.1 Eligibility and Conditions for Coverage (10/29/2014, 14-05P)

Home telemonitoring services will be a benefit for individuals with primary Vermont Medicaid or non-homebound individuals with dual Medicare and Medicaid who are served by Vermont Home Health Agencies in accordance with clinical coverage guidelines, as updated annually and described in the Provider Manual.

7702.2 Qualified Providers (10/29/2014, 14-05P)

Qualified providers are home health agencies enrolled with Vermont Medicaid.

Qualified providers must follow data parameters established by a licensed physician's plan of care.

Qualified providers must use the following licensed health care professionals to review data: registered nurse (RN), nurse practitioner (NP), clinical nurse specialist (CNS), licensed practical nurse (LPN) under the supervision of a RN, or physician assistant (PA). In the event of a measurement outside of the established individual's parameters, the provider shall use the health care professionals noted above to be responsible for reporting the data to a physician

The data transmission must comply with standards set by the Health Insurance Portability and Accountability Act (HIPAA).

7702.3 Reimbursement (10/29/2014, 14-05P)

Reimbursement for telemonitoring services is described in the Provider Manual and updated annually.